MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
Benefits Department

560 N. Park Ave., 4th Floor ◊ PO Box 203203 ◊ Helena, Montana 59620-3203
(877) 501-1722 ◊ Fax (406) 449-9170

OUT-OF-AREA MEDICAL TRAVEL PRIOR AUTHORIZATION APPLICATION

Under certain circumstances, a MUS *Choices* medical plan participant may be approved for reimbursement for out-of-area travel expenses for the sole purpose of receiving medically necessary treatment for covered medical services provided by an out-of-area provider. Please see the MUS Summary Plan Description for specific detailed information. The patient **must** be covered on the MUS *Choices* medical plan at the time services are incurred. To be considered for this benefit, the information requested below **must** be provided prior to travel occurring. For further questions, contact the MUS Benefits Office at 1-877-501-1722.

Out-of-area travel expenses must be prior authorized.
If prior authorization is not obtained, travel expenses will not be reimbursed.

If the Patient chooses to use an Out-of-Network provider, Out-of-Network benefits will apply AND the Patient may be balance billed the difference between the allowed amount and the billed charge for incurred services.

Submit completed form to: MUS Benefits Office, PO Box 203203, Helena, MT 59620 **or** fax (406) 449-9170

Subscriber Information – To be completed by Subscriber or Patient		
Subscriber's Name		Phone Number ( )
Mailing Address		
City	State	Zip
Patient's Medical Plan ID Number		Social Security Number
Patient's Name		Patient's Date of Birth
****REQUIRED INFORMATION**** To be completed by Referring Physician		
Referring Physician's Name		Phone Number ( )
Mailing Address		
City	State	Zip
Diagnosis of Patient Referenced Above		
Will surgery be performed?	Surgical Procedure	
Type of Treatment Recommended		
Is this treatment available in your local area? If so, please explain reasons for seeking out-of-area treatment.		
Estimated Date of Travel	Estimated Cost of Travel	
Provider and Facility patient is being referred to (name, address, and phone number)		
Referring Physician's Signature		

08/22