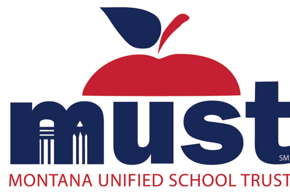

MUST OUT-OF-STATE TRAVEL REQUEST FORM

Dear MUST Plan Participant:

Under certain circumstances, your MUST medical plan will reimburse you for the cost of transportation by regularly scheduled passenger aircraft, railroad, bus, or for round trip fuel reimbursement for a personal automobile (at the IRS approved personal mileage rate). This benefit is for you or your dependent(s) **for travel expenses for the sole purpose of receiving medically necessary services that cannot be provided in Montana** up to $600 per trip under the Travel Benefit. Please see the detailed explanation of the travel benefit on the following page.

This benefit is not subject to Plan deductible or co-insurance and will be reimbursed at 100% of approved expenses. Transportation for treatment within the state of Montana is not covered. To be considered for this benefit, we must have the information requested below **along with a receipt for your travel expense, except when requesting mileage**. Please complete the member information section of this form and have your referring physician complete the medical information section and return this completed form to:

Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, Montana 59604

To be completed by MUST member		
Participant's Name:		Phone Number:
Participant's ID Number:		
Mailing Address:		
City:	State:	Zip:
Patient's Name:		
Patient's Relationship to Participant:		Patient's Date of Birth:
Mode of travel:	Travel date(s):	Cost of airfare (if applicable): Cost of companion airfare (if applicable):
To be completed by referring physician		
Referring Physician's Name:		Phone Number:
Mailing Address:		
City:	State:	Zip:
Patient's diagnosis: Will surgery be performed? Yes: No:		Surgical Procedure:
Type of treatment recommended: Can this treatment be provided in Montana? Yes: No:		
Provider and facility patient is being referred to:		
Address: City:	State:	Zip:
Physician's Signature:		Date:
For BCBSMT Use Only		
Determination:	Codes for payment:	Service reason: TTRVL
Mileage calculation:		Total amount to be reimbursed:
BCBSMT manager signature:		Date:

Revised 03.2020