



KUSPUK SCHOOL DISTRICT  
AIR TRAVEL PRE-AUTHORIZATION SUPPLEMENT FORM  
This form may be photocopied as needed

The Kuspuk School District Employee Healthcare Plan provides, under special circumstances and with certain restrictions, benefits for air transportation for you and your covered dependents. Please read the description of this benefit in the Description of Medical Benefits in the Summary Plan Description. In order to consider such expenses, the Plan must have the information requested below.

Please have the referring physician complete the Medical Information section and mail or fax the completed form to:

**Integrity Administrators, Inc.**  
**P. O. Box 13128**  
**Sacramento, CA 95813-3128**  
**FAX: (916) 921-3383**

It is the covered person's responsibility to submit a copy of the airfare ticket which needs to include the dates of travel and charge (s) for the travel. This may be submitted to the address or fax number shown above.

**Employee's Name:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Travel to and from dates:** \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_

**MEDICAL INFORMATION** (to be completed by referring physician)

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis of Patient: \_\_\_\_\_

Recommended Treatment: \_\_\_\_\_

Will surgery be required?: \_\_\_\_\_ Surgical Procedure: \_\_\_\_\_

If service is not available locally, where is the nearest facility equipped to perform medically necessary procedure? \_\_\_\_\_

When will the procedure be performed: \_\_\_\_\_

Is travel requested for diagnostic testing? \_\_\_\_\_

Is travel requested for second opinion evaluation? \_\_\_\_\_

Physicians Signature: \_\_\_\_\_

Physicians Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_