Travel Verification Form

MERITAIN HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921 Fax: 1.763.852.5057
Email: west.region.claims@meritain.com

IMPORTANT: Please have the referring physician assist you in completing this form. Then, after you travel, mail or fax this completed form, a completed health claim form and the used airfare ticket stub and any applicable receipts to Meritain Health to obtain reimbursement for your airfare.

EMPLOYEE INFORMATION					
Name (last, first, initial)			Sex	Employer Name **Valdez City Schools**	
Home Address			Identification Number	Birthdate	Group Number **AK127**
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	

PATIENT INFORMATION			
The patient is:	☐ **The Employee**	☐ **Employee's Spouse**	☐ **Employee's Child**
Patient's Name (last, first, initial)			Sex
Patient's Birthdate			
Name of Escort: Escort only allowed for the parent or legal guardian of a dependent child under age 18 or an adult accompanying an incapacitated adult (documentation required).			

REFERRING PHYSICIAN Please have the referring physician complete this portion	
Condition	Is this related to any of the following: ☐ **Transgender** ☐ **Transplant** ☐ **Cancer Treatment**
Was this treatment due to an accident or medical emergency?	
Can this treatment be performed locally? ☐ **Yes** ☐ **No** If not, why?	
Physician Signature	Date

By signing below, I am affirming that I have paid for the travel services and am not entitled to reimbursement by any other organization.	
Employee Signature	Date