REQUEST FOR TRICARE PRIME TRAVEL BENEFIT

You may be eligible for the TRICARE Prime Travel Benefit, for more information and assistance in completing the Prime Travel benefit request form, please contact TRICARE Regional Office West Prime Travel Coordinator at: travel.coordinator@TROW.tma.osd.mil

1. Patient Name (Last, First, MI)_____ _____ 2. Patient's Social Security Number:_____	3. Is non medical attendant medically necessary? [ ] Yes [ ] No 3a. Non medical attendants Name: (Last, First, MI)_____ _____ 3b. Non medical attendants address if different than patient:_____ _____ 3c. Non medical attendants social security number:_____
4. Current Patient Address (Street, Apt. No., City, State, & Zip Code) _____ a Address if different when services rendered_____ _____	5. Patient Telephone Number (Including area code) Daytime: [ ] Evening: [ ] Cell: [ ]
6. Sponsor's Name (Last, First, MI)_____ a. Duty Station_____ Duty Telephone #_____ _____ b. Sponsor's Social Security Number_____	7. Patient's relationship to Sponsor: Spouse [ ] Child [ ] a. Patient's relationship to NMA: Parent [ ] Guardian [ ] or Family Member [ ]
8. Primary Care Manager (PCM)Name:_____ PCM Address:_____ (City/Stated/Zip code)	9. Is this Inpatient Care? YES [ ] NO [ ] a. Name of Medical Facility_____ _____

Part I: TDY/Authorization Information

10. Specialty Provider Name and destination:_____ City/State/Zip Code:_____ Type of Specialty: _____	11. Authorization Number_____ a. Authorization begin/end date_____	
12. Travel begin and end date(s):_____		
13. Transportation: [ ] Air (Commercial) [ ] Private Owed Vehicle, [ ] Rental Car (Commercial)	14. Lodging: [ ] Gov't BOQ, Etc., [ ] Hotel [ ] Other	15. Meals: [ ] Gov't Meals [ ] Retroactive out of pocket expenses

Part II – Completed by Program Benefit Validator

Is care medically necessary? Yes [ ] No [ ] Location of Nearest Specialty Provider:_____ _____	DTOD Mileage one way_____ Is Gov't Transportation Practical? Yes [ ] No [ ]

Validator's Signature:_____
Approved/Disapproved

16. Signature of Requestor _____ **Date**_____

NOTE: ***A COPY OF THE TriWest LETTER OF AUTHORIZATION MUST BE ATTACHED TO PROCESS REQUEST***
IF REQUESTING A *NON-MEDICAL ATTENDANT* A LETTER FROM THE *REFERRING PROVIDER* IS REQUIRED

Revised APR 2005

HOW TO FILL OUT THE TRICARE PRIME TRAVEL FORM

1. Enter patient's name, last name, first name, and middle initial as it appears on the military ID card. Do not use nicknames. *2. Enter the patient's Social Security Number (SSN).* *3. Indicate whether a non-medical attendant (NMA) needs to accompany the patient for travel. Statement needed from referring provider indicating NMA is required.* *3a. Enter the NMA's name; first name, last name, and middle initial.* *3b. Enter the NMA's address if different from patient.* *3c. Enter the NMA's Social Security Number (SSN).* *4. Enter the patient's current address (street number, street name, apartment number, city, state, zip code).* *4a. Enter address if different from when services were rendered.* *5. Enter the patient's daytime, evening and cell telephone number to include area code.* *6. Enter the Sponsor's name; first name, last name, and middle initials.* *6a. Enter the Sponsor's current military duty station and telephone number.* *6b. Enter the Sponsor's Social Security Number (SSN).*	*7. Check the box to indicate patient's relationship to sponsor.* *7a. Check box to indicate patient's relationship to NMA's.* *8. Primary Care Manager's Name and Full Address including zip code* *9. Check box to indicate if patient is being hospitalized.* *9a. Enter the name and location of the medical facility.* *10. Enter Specialty provider name and facility address of destination traveled (street name, street number, city, state, zip code). Enter type of specialty of the Provider you were refer to.* *11. Enter authorization number provided in TriWest letter.* *11a. Enter begin and end date of the authorization.* *12. Enter begin and end date(s) of travel (mmddyyyy).* *13. Check box to indicate the type of transportation used for travel.* ***MUST BE GOVERNMENT PROCURED AND AUTHORIZED****.* *14. Check box to indicate the type of lodging you will use during your authorized travel dates. If you check other please specify.* *15. Check box to indicate the type of expenses for meals.* *16. Beneficiary/Claimant Must sign and date this block in order for the request to be process.* ***DO NOT FILL OUT PART II OF THIS FORM*** *- THIS WILL BE FILLED OUT BY THE HBA/BCAC WHO VALIDATES YOUR TRAVEL*

Mail travel request form to:

TRICARE Regional Office WEST
Attn: PRIME Travel Coordinator
401 West A Street, Suite 2100
San Diego, CA 92101-7908