

TRICARE PATIENT TRAVEL INFORMATION FORM

TRICARE Regional Office - South
 7800 IH-10 West, Suite 400
 San Antonio, TX 78230
 Travel Phone: (800) 576-0375
 Travel Fax: (210) 5366176

Date:

Travel e-Mail: dha.jbsa.health-opns.mbx.trosouthtravel@mail.mil

PRIME TRAVEL BENEFIT (PTB)

COMBAT-RELATED SPECIAL COMPENSATION (CRSC) TRAVEL BENEFIT

Patient Information

Patient Name: _____
 Patient Date of Birth: _____
 Patient SSN: _____
 Patient Address: _____
 Patient City/State: _____
 Patient Zip Code: _____
 Patient Daytime Phone: _____
 Patient e-mail: _____

Military Sponsor's Information

Sponsor Name: _____
 Sponsor SSN: _____
 Sponsor Status: _____
 Branch of Service: USAF USA USCG
 USMC USN USPHS

Non-Medical Attendant (NMA) Information

*Please ensure a NMA medical necessity letter from the patient's doctor accompanies all NMA claims (for ALL adults 18 years or older).
 *AD members must also have an organizational memo with their claims authorizing them to serve as an NMA.

NMA Memo Attached: YES NO
 NMA Name: _____
 NMA SSN: _____
 Relation to Patient: _____
 NMA Daytime Phone: _____
 NMA e-Mail: _____
 Civilian (CIV) Govt Employee: YES NO
 Active Duty (AD) Military: YES NO
 Rank/Grade: _____
 NMA Status: AD Retire Other

Mode of Travel POV Rental Car
 Air Other

CLAIMANT SIGNATURE: _____

By signing you attest that all information provided on this form is accurate and valid.

Primary Care Manager Information

PCM Name: _____
 PCM Address: _____
 PCM City/State: _____
 PCM Zip Code: _____
 PCM Phone: _____

Specialty Care Provider (SCP) Information

SCP Name: _____
 SCP Address: _____
 SCP City/State: _____
 SCP Zip Code: _____
 SCP Phone: _____
 Type of Specialty: _____

Medical Appointment Information

Travel Departure Date:
 Travel Return Date:
 First Appt Date: Last Appt Date:
 First Appt Time: Last Appt Time:
 First Appt: AM PM Last Appt: AM PM
Inpatient: YES NO AM
 Admission Date/Time: PM
 Discharge Date/Time: PM

Specialty Care Referral/Authorization Information

Authorization Number: _____
 Other Health Insurance (OHI): YES NO
 PCM Referral Letter Attached: YES NO

CRSC Required Documents ONLY

CRSC Determination Letter Attached: YES NO
 PCM Referral Letter Attached: YES NO
 SCP Provider Treatment Confirmation Letter Attached: YES NO

TRO OFFICE USE ONLY

Date Received	<input type="text"/>	DTOD Distance PCM-SCP	_____
Attestation on File/Category	_____	DTOD Distance HOME-SCP	_____
TRICARE Prime, Standard, TFL	_____	PTBP Coord Verification Name	_____
OHI	_____	Completion Date	<input type="text"/>

This document may contain information covered under the Privacy Act, 5 USC 522(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions.