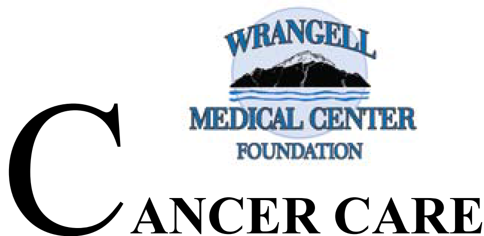

CANCER CARE

Wrangell Medical Center
Cancer Care
PO Box 1081
Wrangell, AK 99929
Phone 907-874-7000
Fax 907-874-7170

TRAVEL ASSISTANCE APPLICATION

PATIENT INFORMATION (Please print)

NAME ______________________ PHONE NUMBER ______________________

ADDRESS ______________________ AGE ____________

CITY ____________ STATE ________ ZIP CODE ____________

PHYSICIAN ______________________ DIAGNOSIS ______________________

INSURANCE/SEARHC/MEDICAID ______________________

I herby authorize my physician to release my diagnosis to Wrangell Medical Center Foundation, Cancer Care for the purpose of establishing eligibility for travel assistance. I understand this authorization is voluntary.

PATIENT SIGNATURE ______________________ DATE ______________________

ASSISTANCE MAY BE REQUESTED EVERY YEAR, UP TO A MAXIMUM OF $1,000.00

Cancer Care Travel Assistance Program is a "reimbursement" program. **The patient must submit receipts to Cancer Care for their travel expenses incurred.** Examples of patient expenses include documentation for airfare, lodging, rental car, gasoline, taxis, shuttle bus, ferry tickets or other expenses related to travel outside their community for treatment (*food expenses are not covered*). Please also note any other (non–insurance) assistance you have received and the name of the agency the funds were received from. Patients mail or FAX receipts to Cancer Care at the address in the upper right hand corner of this form. Service area: Southern Southeast Alaska (Petersburg/Kake and areas south).

ASSISTANCE REQUIRED: (office use only)
AIR/FERRY TRANSPORTATION: ________________
HOTEL: ________________
GROUND TRANSPORTATION: ________________
TOTAL: ________________
BENEFIT PAID: ________________
BENEFIT YEAR: ________________

DATE RECEIVED: ________________
DATE REVIEWED: ________________
☐ APPROVED ☐ DENIED

____
Approval Signature #1

____
Approval Signature #2