



Wrangell Medical Center
Cancer Care
PO Box 1081
Wrangell, AK 99929
Phone 907-874-7000
Fax 907-874-7167

TRAVEL ASSISTANCE APPLICATION

PATIENT INFORMATION (Please print)

NAME

PHONE NUMBER

ADDRESS

AGE

CITY

STATE

ZIP CODE

PHYSICIAN

DIAGNOSIS

INSURANCE/SEARHC/MEDICAID

I hereby 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 travel expenses incurred. Examples of 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. Patients mail or FAX receipts to Cancer Care at the address in the upper right hand corner of this form.

ASSISTANCE REQUIRED: (office use only)

AIR/FERRY TRANSPORTATION: _____

HOTEL: _____

GROUND TRANSPORTATION: _____

TOTAL: _____

DATE RECEIVED: _____

DATE REVIEWED: _____

APPROVED

DENIED

Approval Signature #1

Approval Signature #2