

Cancer Connection

Lynne Wunsch Memorial Travel Program

8711 Teal Street Suite 302

Juneau, AK 99801-0329

(907) 796-2273

FAX (907) 463-2616

**Travel Assistance Patient Data** **Form**

**Patient Information (please print):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Email Address

**Cancer related reason for travel: \_\_\_\_\_** treatment/surgery; \_\_\_\_\_\_diagnostic; \_\_\_\_\_follow-up care.

(Please check all that apply)

*I hereby authorize my physician to release my diagnosis to Cancer Connection for the purpose of establishing eligibility for travel assistance. I understand this authorization is voluntary. I have also reviewed the allowable conditions for travel reimbursement, and understand reimbursement eligibility is limited to my own expenses incurred, up to Cancer Connection’s annual cap.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

**Assistance Required** (to be completed by Health Care Provider)

Transportation to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location Treatment Center Name

# Certification of Physician

This patient has a positive diagnosis of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation of Cancer

I hereby certify that the patient is traveling outside their community for cancer treatment.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send completed form to *Cancer Connection* at the address above

**This is a “reimbursement” program. Recipients must submit receipts to Cancer Connection 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. Recipients may FAX or mail receipts to the address in the upper righthand corner of this form. Or email to** [**admin@cancerconnectionak.org**](mailto:admin@cancerconnectionak.org)**. (revised 8/29/23)**

***\*\* Prior year receipts must be received by 3/31 of current year to be considered for reimbursement*.**