Medical Referral Travel Form

Please complete this form if you are traveling for medical reasons. Attach this form to your Extended Health Claim form when submitting your medical travel expenses to Pacific Blue Cross for reimbursement.

Part 1: To be completed by Referring Physician

Patient's Name	Referring Physician's Name	Referred To	Referral Physician's Specialty

Referring Physician's Street Address	City	Province	Postal Code

Location Referred to:	Referral Date (mm/dd/yyyy)	Appointment Date (mm/dd/yyyy)

Reason for Referral

Attendant/escort required? ☐ No ☐ Yes	Reason(s) the attendant/escort is required
Are further appointments necessary? ☐ No ☐ Yes	If yes, how often?

If there is more than 2 months between the referral and the appointment dates, please explain why

Part 2: Employee and Referring Physician Signature

I certify that the statements are accurate, true and complete in all respects.

Referring Physician's Signature ______________________ Date Signed (mm/dd/yyyy) ______________

I certify the above statements are correct, and I authorize my physician and hospital to give Pacific Blue Cross any additional information required in connection with this claim.

Employee Signature ______________________ Date Signed (mm/dd/yyyy) ______________

Part 3: To be completed by the Referral Physician

Patient's Name	Treatment Date (mm/dd/yyyy)

Are additional appointments Required?	☐ No	☐ Yes	If yes, please provide the date of the next appointment (mm/dd/yyyy)

Referral Physician's Street Address	City	Province	Postal Code

Type of Treatment:

Referral Physician's Signature ______________________ Date Signed (mm/dd/yyyy) ______________