KAISER PERMANENTE®

PATIENT TRAVEL INTAKE FORM

Please fill out ALL the information requested on this form. Once all the information has been filled out and sent back, we can arrange necessary travel. Thank you for taking the time to be thorough and complete, resulting in a faster turnaround.

NAME / DOB	
HOME ADDRESS	
PHONE NUMBER	
EMAIL ADDRESS	
MEDICARE OR NON-MEDICARE	
MEDICALLY NECESSARY TRAVEL COMPANION (REQUESTED: Y or N)	
MRN # KPWA#	
SURGERY DATE	
INPATIENT DAYS	
TRAVEL DATE (out of SEATTLE)	
TRAVEL DATE (return to SEATTLE)	
LOCATION OF PROCEDURE OR OFFICE VISITS (ADDRESS)	
NOTES: (including lodging, if already established)	

Return completed form by email to: KPWATravel@kp.org