DRIVE TIME WAIVER

Use this form to acknowledge and accept that you may be expected to travel more than 30 minutes for primary care and an hour for specialty care from your home.

Fields marked with an asterisk (*) are required.

Step 1: Complete Sponsor and Beneficiary Information

*Sponsor Name:		*Sponsor SSN or DBN:
*Street Address:		
*City:	*State:	*ZIP Code:

Please list all beneficiaries at this address for whom this waiver should apply.

Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:
Beneficiary Name:	Beneficiary Name:

Step 2: Acknowledge Access to Care/Drive Time Waiver

I understand that by signing this statement, I acknowledge and accept my travel time for primary care may exceed 30 minutes from my home and my travel time for specialty care may exceed one hour from my home.

Step 3: Sign Request Form

NOTE: Request will not be processed without signature.

*Signature:	Date (MM/DD/YYYY):
Relationship to Sponsor:	

Step 4: Mail or Fax Signed Form

Mail:
TriWest Healthcare Alliance
P.O. Box 8550
Virginia Beach, VA 23450

Fax:
866-566-9915

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