

# Invitational Travel Authorization (ITA) Request Worksheet

1. Patient's Name: \_\_\_\_\_ 2. Patient's Date of Birth: \_\_\_\_\_
3. Patient's Category (Circle One): DEP/RET/DA CIVILIAN/ \_\_\_\_\_
4. Sponsor's SSN: \_\_\_\_\_ 5. Patient's SSN: \_\_\_\_\_
6. Patient's Address: \_\_\_\_\_
7. Patient's Day Time Phone Number: \_\_\_\_\_
8. Travel Purpose: \_\_\_\_\_
9. Is this a case management issue (i.e., complex medical needs/multiple systemic issues)? Are you being managed? (Circle One): Yes No (Case Manager): \_\_\_\_\_
10. Approximate number of TDY Days (including travel): \_\_\_\_\_
11. Travel Date: \_\_\_\_\_ Return Date: \_\_\_\_\_
12. Itinerary: **From: Fox Army Health Center, RSA To** (if medical appointment, include doctor's name/location): \_\_\_\_\_  
(Example: **To:** Dr. Smith, Kirklin Clinic, Birmingham, AL)
13. (Circle One): Outpatient or Inpatient
14. Transportation Mode (Circle One): POV Commercial Air Other \_\_\_\_\_
15. If flying Commercial, will you require a rental car? Yes \_\_\_ No \_\_\_
16. Copy of Referral Required (**BEFORE TRAVEL. Must be specialty treatment network provider**)
17. Will there be an attendant/escort (Must be authorized by primary care manager): Yes \_\_\_ No \_\_\_
18. Name of Attendant: \_\_\_\_\_
19. Attendant's Relationship to Traveler: \_\_\_\_\_ (Circle One): DEP/RET/Other
20. Attendant's SSN: \_\_\_\_\_

NOTE: Airfare is authorized for trips over 400 miles one way. If the traveler chooses to drive instead of fly, reimbursement will be limited **ONLY** to what it would cost for airfare, CTO fee, baggage fee and taxes. If the traveler chooses to drive, mileage reimbursement will **ONLY** be for the most direct route to and from the specialty treatment network provider.

Direct questions about completing this worksheet to the ITA Coordinator, Jacqueline Roach  
(256)955-8888 Ext. 1047 or to Valeria Hills, Chief, Patient Administration, (256)955-8888, Ext.  
1031.

**Privacy Act of 1974 and HIPAA are applicable when worksheet is completed.**