



## Traveler Encounter Form

Please complete as many of the fields below as you can. After submission, allow 48 hours for a staff member to contact you. If you have an immediate travel need, please call **866-450-0060, ext 83** for emergency assistance. Upon completion of this form, fax to 919-287-2973 to the attention of Hospital Traveler Benefits Coordinator.

Patient First Name:	<input type="text"/>
Patient Middle Name:	<input type="text"/>
Patient Last Name:	<input type="text"/>
Apartment Number:	<input type="text"/>
Street Address:	<input type="text"/>
Town / City:	<input type="text"/>
State:	<input type="text"/>
Zip Code:	<input type="text"/>
Country:	<input type="text"/>
Primary Telephone Number:	<input type="text"/>
Secondary Telephone Number:	<input type="text"/>
Email Address:	<input type="text"/>
Date of Birth:	<input type="text"/>
Medicaid Number:	<input type="text"/>
Insurance Company Name:	<input type="text"/>
Insurance Company Contact Number for Providers:	<input type="text"/>
Primary Person Insured:	<input type="text"/>
Attendant First Name:	<input type="text"/>
Attendant Last Name:	<input type="text"/>
Relationship to Attendant :	<input type="text"/>
Medical Facility Traveling To:	<input type="text"/>
Projected Arrival:	<input type="text"/>
Anticipated Departure:	<input type="text"/>