NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN
20547 Waverly Court, Ashburn, Virginia 20149
Brian L. Renfroe, President • **Stephanie M. Stewart,** Director

Travel Request

Name: _____

Member ID: _____

Phone: _____

Are you enrolled in SilverScript: Yes ☐ No ☐ **SilverScript ID:** _____

Request is due to: **Deployment:** ☐ **School:** ☐ **Work Travel:** ☐ **Vacation:** ☑

Destination: _____

Departure Date: _____

Returning: _____

Signature of patient: _____

Name of drug(s): _____

_____

Controlled medications may require additional information.

This form is for use when a short-term vacation leaves you without access to a CVS Pharmacy or other participating pharmacy to meet your needs away from home.

Vacation requests for medications are not intended for extended periods. However, if this request is due to deployment, school or work-related travel, please also submit the corresponding documentation to confirm the need for an extension. **If your vacation prescription request is approved, the Plan will allow one fill per medication.** If your vacation prescription request is not approved, or if you must purchase medications while on vacation, refer to the Plan's current brochure for instructions on obtaining reimbursement using the short-term prescription claim form.

Please leave a good callback number for the Plan to call when your request is completed.

Fax to the attention of the NALC CDHP Department at (703) 729-0076.