

## Request for Coverage of a Non-Medical Escort

The Non-Insured Health Benefits (NIHB) policy for Non-Medical Escorts is found in Section 5.5 of the NIHB *Medical Transportation Policy Framework*. The provision of a non-medical escort may be approved, following a treating health professional's **request** only when there is a legal or medical requirement.

**Non-medical escorts cannot be considered based on 'compassionate grounds'.** (Section 12.1 Exclusions)

### Section 1 – Client Information and Consent

Client's Full Name: \_\_\_\_\_

Date of Birth( dd/mm/yyyy):     /     /     Client ID #: \_\_\_\_\_

#### CLIENT CONSENT FOR RELEASE OF INFORMATION

I consent to the disclosure of any personal medical information to NIHB to support my request for coverage of medical transportation benefits.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Section 2 – Medical Information

***This section must be completed and signed by a treating Health Professional***

Y     N     Cognition:    Does the client have any significant limitations with memory, concentration or problem solving?

Y     N     Senses:        Does the client have any significant limitations with sight, hearing or speech?

Y     N     Mental Health: Does the client have mental health issues that cause significant difficulty in dealing with other people?

Y     N     Personal:      Does this client have significant limitations with their own activities of daily living?

If YES to any of the above, please describe how this affects their ability to travel without a non-medical escort:

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Y     N     Does the client have significant mobility issues?

If YES, please clarify if these issues are short-term or permanent, and if the client requires assistance with mobility at home:

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Y     N     Is there a medical contra-indication to the client traveling alone by bus? If yes, please explain:

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What is the most significant medical risk of the client traveling alone?

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**Section 3 – Language**

***This section must be completed and signed by a Physician/Community Health Professional\*.***

Y  N  Language Barrier: Does a language barrier prevent this client from accessing medically required services?

**Section 4 – Health Professional Signature**

***This section must be completed and signed by a treating Health Professional***

**PLEASE SELECT OPTION #1 OR #2****#1**

**As the treating health professional, I consider it necessary for this client to have a non-medical escort covered (check all that apply):**

- while the client is travelling both ways between home and their medical appointment.
- while the client is admitted to hospital. **Please explain why the hospital staff cannot fulfill the client's needs:**  
\_\_\_\_\_
- to travel home at the time of discharge after an admission to a medical facility
- while the client is staying near the hospital, as instructed, after surgery or during extended out-patient treatment
- other (please describe):  
\_\_\_\_\_

**Anticipated duration**

- This client will require a non-medical escort from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
yyyy / mm / dd                      yyyy / mm / dd
- Long Term: To be reassessed by NIHB every year with an updated non-medical escort request submitted by a treating health professional

**OR:****#2**

- I DO NOT consider it medically necessary for this client to have a non-medical escort.**

Treating Health Professional Name (please print): \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Role in Client's Medical Care: \_\_\_\_\_ Date of assessment (yy/mm/dd): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Treating Health Professional Address: \_\_\_\_\_