

Medical Transportation Reimbursement Form – Qalipu First Nation

All requests for reimbursement of eligible benefits must be made **within one year from the date of service**. Please submit ALL required documents and keep a copy of this form with all supporting documents for your records. **Forms that are unsigned or incomplete will be returned.**

Call for prior approval toll-free at 1-855-675-5743

NIHB Travel Authorization Number:					-										
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Section 1 - Client Information (client receiving the service)

Client's Full Name: _____

Date of Birth: _____ / _____ / _____
dd / mm / yyyy

Client ID #: _____

Client's Home Address: _____ Phone Number: (____) _____

City: _____ Prov: _____ Postal Code: _____

Non-Medical Escort=s Name (requires prior approval unless client is a minor): _____

Escort ID# (if applicable): _____

Are you covered for any of these expenses under any other health plan(s)/program(s)? Yes ____ No ____
If YES, please attach a copy of a detailed statement or explanation of benefits form from all other plan(s)/program(s).

Section 2 - Payment Information

Please provide the name and address of the person or organization to which payment should be made. The payee must be the provincial legal age.

IF PAYEE INFORMATION IS THE SAME AS THE CLIENT INFORMATION CHECK HERE

Cheque payable to: _____

Mailing Address: _____

City: _____ Prov: _____ Postal Code: _____

Section 3 - Appointment Information

Confirmation of attendance **must be completed** OR a confirmation from the health facility attached. See page 3 for additional confirmations. **Include the name of the Health Professional seen or the type of diagnostic test performed.** Medical justification is required when travel is beyond the nearest facility. The appointment service must be insured by your provincial health plan (MCP, MSI, NB Medicare, PEI Medicare) or NIHB for medical transportation.

Appointment Date: _____ / _____ / _____ Appointment Time in: _____ Appointment Time out: _____
dd / mm / yyyy

Physician/Health Professional's Name: _____ Phone Number : (____) _____
(print)

Name and Address of Health Facility: _____

Signature or stamp from Health Facility (**mandatory**): _____

Section 4 - Claim Information		
Please check all that apply.	For Internal use only	
<input type="checkbox"/> TRANSPORTATION: Receipts for fuel are not required # of Kilometres travelled (return trip) x NIHB rate = Total Claimed _____ km x \$ _____ = \$ _____ Total Transportation Claimed Original itemized receipt(s) must be attached for the following items: Tolls: \$ _____ Bridge: \$ _____ Parking: \$ _____ Other: \$ _____	COB Paid	Amount to be Paid
<input type="checkbox"/> ACCOMMODATIONS: For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached. Private accommodations: \$13.50/night per person \$ _____ Total Accommodations Claimed		
<input type="checkbox"/> MEALS: Approved if travel time away from home is over 6 hours (receipts are not required). NIHB Daily Rates: Breakfast \$12 Lunch \$12 Dinner \$24 Rates are half for children under 5 years of age NIHB Weekly Rates (5 days or more): \$168/week for one person \$252/week for two people Total # Adult Meals Claimed: Breakfast _____ Lunch _____ Dinner _____ Total # Child Meals Claimed: Breakfast _____ Lunch _____ Dinner _____ \$ _____ Total Meals Claimed		
Total \$: _____	Analyst:	Total \$ _____

Section 5 - Authorization and Signature
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Health Canada requires your authorization in order to collect information from your medical provider (including confirmation of appointment attendance) for services provided to you.

I authorize the release of any records that are relevant to the processing and payment of this claim to Health Canada, it's agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by Health Canada or by any other plan(s)/program(s) that is noted in the statement or explanations of benefits.

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** ____ / ____ / ____
 (Signature is mandatory. If client is under the age of 16, then the parent / legal guardian must sign) yyyy/mm/dd

Mail this completed form along with receipts (if applicable) to:

Qalipu First Nation
 3 Church Street
 Corner Brook, NL A2H 2Z4

Privacy statement

Health Canada also requires your authorization in order to collect information from your medical provider for services provided to you and paid for by the Non-Insured Health Benefits Program. The NIHB Program is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the NIHB Program collects, uses, discloses and retains your personal information in accordance with the applicable federal privacy laws and policies. Further details of the NIHB Privacy Code can be found on the Health Canada website:

http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php