Qalipu
FIRST NATION

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:					-			-					

Section 1 - Client Information (client receiving the service)

Client's Full Name:_____

Date of Birth:_____/_____/_____ (dd / mm / yyyy) Band Registration #:_____

Clients Home Address:_____Phone Number: (_____)_____

City: _____ Prov: _____ Postal Code: _____

Non-Medical Escorts 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 Non-Insured Health Benefits for medical transportation.

Did you travel past the nearest health facility? **Yes** ☐ **No** ☐ **(If yes, please provide medical justification)**

Appointment Date:_____/_____/_____ (dd / mm / yyyy) Appointment Time in:_____ Appointment Time out_____

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

Name and Address of Health Facility:_____

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

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Section 4 - Claim Information

Please check all that apply.	For Internal use only	
☐ **TRANSPORTATION:** Receipts for fuel are not required Original itemized receipt(s) must be attached for the following items: Tolls: $_____ Bridge: $_____ Parking: $_____ Other: $_____ For office use only:	**COB Paid**	**Amount to be Paid**
☐ **ACCOMMODATIONS:** For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached. Private accommodations: $13.50/night per person ☐ For office use only:		
☐ **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 For office use only:		
	Analyst:	**Total $** _____

Section 5 - Authorization and Signature

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) dd / mm / yyyy

Mail this completed form along with receipts (if applicable) to:
Qalipu Mi'kmaq First Nation Band
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.

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1. Appointment Date:____/____/____ Appointment Time in:_____ Appointment Time out_____
yyyy/mm/dd
Physician/Health Professional's Name:_____ Phone Number:(____)_____
(print)
Name and Address of Health Facility:_____

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

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2. Appointment Date:____/____/____ Appointment Time in:_____ Appointment Time out_____
yyyy/mm/dd
Physician/Health Professional's Name:_____ Phone Number:(____)_____
(print)
Name and Address of Health Facility:_____

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

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3. Appointment Date:____/____/____ Appointment Time in:_____ Appointment Time out_____
yyyy/mm/dd
Physician/Health Professional's Name:_____ Phone Number:(____)_____
(print)
Name and Address of Health Facility:_____

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

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4. Appointment Date:____/____/____ Appointment Time in:_____ Appointment Time out_____
yyyy/mm/dd
Physician/Health Professional's Name:_____ Phone Number:(____)_____
(print)
Name and Address of Health Facility:_____

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

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5. Appointment Date:____/____/____ Appointment Time in:_____ Appointment Time out_____
yyyy/mm/dd
Physician/Health Professional's Name:_____ Phone Number:(____)_____
(print)
Name and Address of Health Facility:_____

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