Health Canada | Santé Canada

Atlantic Region's Claim for Medical Transportation Reimbursement

All requests for reimbursement of eligible benefits must be made within one year from the date of service. It is important to submit ALL required documents. Please keep a copy of this form and all supporting documents for your records.

INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

- Did you submit your original receipt(s)? Credit card/Debit (Interac) slips are not acceptable forms of proof of payment?
- Did you include confirmation of medical appointment attendance or complete Section 3?
- Did you complete and sign all applicable parts of this NIHB Client Reimbursement Request Form? **Forms that are unsigned or incomplete will be returned**.

Trips require Prior Approval by calling NIHB toll-free at 1-800-565-3294

NIHB Travel Authorization Number:					–			–					

Section 1 - Client Information (client receiving the service)

Client's Full Name:____

Date of Birth: _____/____/______ Day/Month/Year

Client ID # :______________________________

Client's Address:____

____

Client Phone Number: (_____)____________________________________

Escort's Name and ID#:____

Section 2 - Payment Information

All parts of this section must be completed in order for reimbursement to be paid.

Please provide the name and address of the person/facility to whom payment should be made. The payee must be over the provincial legal age.

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

Reimbursement cheque should be made payable to:________________________________

Address:____

____

Phone Number: (______)____

Privacy statement
Health Canada also required 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.

Section 3 - Appointment Information

Confirmation of attendance <u>must be completed.</u> All information must be provided in order to be considered for reimbursement including the signature from the health facility.
You may attach a written confirmation of attendance from the health facility.

Appointment Date:______/______/_______ Appointment Time in:_______ Appointment Time out______
Day/Month/ Year

Health Professional's Name:______________________ Health Facility's Phone Number: (______)________________
(print)

Name and Address of Health Facility:____

____

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

Section 4 - Claim Information

Is the health service identified in **"Section 3 - Appointment Information"** being covered by your provincial health plan or by the Non-Insured Health Benefits Program? Yes _____ No _____

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).

<u>PLEASE INDICATE WHAT MEDICAL TRANSPORTATION BENEFITS ARE BEING CLAIMED</u>

☐ **TRAVEL DISTANCE:** # Kilometres (Return Trip) ____________ x $ __________ = $_______________

☐ **ACCOMMODATIONS** *(when prior approved for trips over 600 km return)* ***Original Receipt(s) for commercial accommodations must be attached)***:
Name of Accommodation Facility:____

Accommodations Cost: $_______________

☐ **MEALS** (*approved if travel time away from home is over 6 hours. Receipts are not required*):
Meal Cost: # _____ x $6.00 Breakfast(s) # _____ x $9.00 Lunch(es) # _____ x $15.00 Dinner(s)

*Rates are half for children under 12 years of age
**Weekly NIHB Meal Rates $75.00/week for one person, $110.00/week for two people

Section 5 - Authorization and Signature

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider 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.

Patient's Signature:___________________________________ Date: ______________
(This signature is mandatory. If client is under the age of 16, then the parent / legal guardian must sign)

Mail this completed form along with receipts (if applicable) to:
Non-Insured Health Benefits, First Nations & Inuit Health Branch, Health Canada
Suite 1525, 1505 Barrington Street Halifax, NS B3J 3Y6
Fax: 1800-377-9288