Medical Transportation Reimbursement Form - Atlantic Region

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 NIHB for prior approval toll-free at 1-800-565-3294, Local (902) 426-2656

NIHB Travel Authorization Number:					–			–					

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:_____

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

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

Name and Address of Health Facility:_____

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

Section 4 - Claim Information

Please check all that apply.	For NIHB Internal use only	
☐ **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**	**NIHB 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 for adults and $6.75/night for children under 12 years of age. $ _____ Total Accommodations Claimed		
☐ **MEALS:** Approved if travel time away from home is over 6 hours (receipts are not required). NIHB Daily Rates: Breakfast $6 Lunch $9 Dinner $15 Rates are half for children under 12 years of age NIHB Weekly Rates: used for clients who stay at an efficient unit or private accommodations: $75/week for one person $110/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

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.

(This signature is mandatory. If client is under the age of 16, then the parent / legal guardian must sign)

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** ____/____/____
dd / mm / yyyy

Mail this completed form along with receipts (if applicable) to:
First Nations & Inuit Health Branch, Non-Insured Health Benefits
Suite 1525, 1505 Barrington Street Halifax, NS B3J 3Y6
Fax: 1-866-963-7700 (only when original receipts are not required)

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.

1. 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)**: _____

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2. 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)**: _____

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3. 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)**: _____

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4. 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)**: _____

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5. 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)**: _____

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6. 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)**: _____