

NIHB Medical Transportation Client Reimbursement Form

Instructions:

- You have one year from the date the service(s) was provided to apply for reimbursement.
- Remember to include your Band registration (or identification) number.
- Ensure you have **signed** and completed all sections of your reimbursement form and included all necessary documents, or your claim will be returned to you.
- Original receipts are required, therefore faxed copies of your claim will not be accepted.
- If you have received prior-approval for your medical trip, please be sure to include the Travel Authorization (TA) number in your claim.
 - Note: TA numbers are only valid for one trip. The next trip you take will require a new preapproval and TA number. Please contact a NIHB Support Specialist by calling 709-634-0996.
- If you are required to travel beyond the nearest health facility, medical justification will be needed.
 Medical Justification explains why you had to travel past the nearest Health Facility for your medical needs.
 - You may have your **health care provider** complete the Benefit Exception Request Form (see link below) and submit this form with your claim.
- Sign up for Electronic Funds Transfer (EFT) to receive your reimbursement.
 - Complete the Electronic Funds Transfer Form (see link below) and mail it to the address below or call 709-634-0996 to speak to a Support Specialist to discuss emailing it in.
- All Medical Transportation reimbursement claims must be mailed to the Corner Brook office at:

NIHB Medical Transportation Program
3 Church Street
Corner Brook, NL
A2H 2Z4

Contact Information:

- To set up a pre-approval for your medical transportation requirement please call 709-634-0996 to speak to a Support Specialist.
- For general inquiries regarding medical transportation call 709-634-0996 to speak to a Support Specialist.

Supporting Documents:

- Click here to access the Benefit Exception Request Form
- Click here to access the EFT Direct Deposit Form

Note: The documents listed below can also be found on http://qalipu.ca/health/non-insured-health-benefits/ or at your local band office.



Medical Transportation Reimbursement Form – Qalipu First Nation

All requests for reimbursement of eligible benefits must be made <u>within one year from the date of service</u>. 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. Faxed claims will <u>NOT</u> be accepted.

Call to Speak to a Support Specialist for Prior Approval 709-634-0996

| Section 1 - Client Information (client receiving the service) | | | |
|---|--|--|--|
| Client's Full Name: | | | |
| Date of Birth: / / Band Registration #: | | | |
| Clients Home Address:Phone Number: () | | | |
| City: Prov: Postal Code: | | | |
| Non-Medical Escorts Name (requires prior approval unless client is a minor): | | | |
| 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 letter from the health facility must be attached. See page 3 for additional confirmations if additional space is required for multiple appointments. 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 reimbursement. | | | |
| Did you travel past the nearest health facility? Yes No (If yes, please provide medical justification) | | | |
| Appointment Date: / / 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 Internal use only | | | |
| TRANSPORTATION: Receipts for fuel are not required | COB Paid | Amount to be Paid | | |
| Original itemized receipt(s) must be attached for the following items: | | | | |
| Tolls: \$ Bridge: \$ Parking: \$ Other: \$ | | | | |
| For office use only: | | | | |
| 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 \$15 Lunch \$15 Dinner \$30 Rates are half for children under 3 years of age (inclusive) | | | | |
| 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:SIGNATURE:Signature is mandatory. If client is under the age of 16, the parent / le | and appealing con- | DATE:// | | |
| Signature is mandatory. If client is under the age of 16, 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

Faxed claims will be returned, and a mailed copy will be requested

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: https://www.sac-isc.qc.ca/eng/1578072742668/1578072802513.



Additional Appointment Confirmations

This page may be used instead of appointment confirmation letters from your health professionals.

| 1. | Appointment Date (yyyy/mm/dd):/ |
|----|---|
| | Appointment Time in: Appointment Time out: |
| | Physician/Health Professional's Name (Print): |
| | Phone Number: () |
| | Name and Address of Health Facility: |
| | Signature/Stamp from Health Facility (Mandatory): |
| 2. | Appointment Date (yyyy/mm/dd):/ |
| | Appointment Time in: Appointment Time out: |
| | Physician/Health Professional's Name (Print): |
| | Phone Number: () |
| | Name and Address of Health Facility: |
| | Signature/Stamp from Health Facility (Mandatory): |
| 3. | Appointment Date (yyyy/mm/dd):/ |
| | Appointment Time in: Appointment Time out: |
| | Physician/Health Professional's Name (Print): |
| | Phone Number: () |
| | Name and Address of Health Facility: |
| | Signature/Stamp from Health Facility (Mandatory): |
| 4. | Appointment Date (yyyy/mm/dd):/ |
| | Appointment Time in: Appointment Time out: |
| | Physician/Health Professional's Name (Print): |
| | Phone Number: () |
| | Name and Address of Health Facility: |
| | Signature/Stamp from Health Facility (Mandatory): |
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