Benefit Exception Requests

Please complete ONLY the section(s) that applies to the request
Section 1 and 5 must be completed

SECTION 1: CLIENT INFORMATION (MUST BE COMPLETED)

Client's Full Name: _____

Date of Birth (yyyy/mm/dd): ____/____/____ Client ID #: _____

SECTION 2: NON-MEDICAL ESCORTS

The Non-Insured Health Benefits (NIHB) policy for Non-Medical Escorts is found in Section 5.5 of the NIHB *Medical Transportation Policy Framework*. The provision of one non-medical escort may be approved, following a health professional's **request** only when there is a legal or medical requirement.
Non-medical escorts cannot be considered based on 'compassionate grounds'. (Section 12.1 Exclusions)

As a health professional, I consider it medically necessary for this client to have one non-medical escort

#1 PLEASE SELECT ALL THAT APPLY

- ☐ Needs assistance prior to or immediately after a medical procedure (e.g. general anesthetic for day surgery)
- ☐ Requires alternative legal consent/decision making
- ☐ Requires assistance with activities of daily living while travelling (not for hospital admission)
- ☐ To receive instruction on specific and essential home medical/nursing procedures before discharge
- ☐ A language barrier prevents this client from accessing medically required services

#2 PLEASE SELECT ALL THAT APPLY

- ☐ While the client is travelling both ways between home and their medical appointment.
- ☐ While the client is admitted to hospital. **Please explain why the hospital staff cannot fulfill the client's needs:**

  _____
- ☐ To travel home at the time of discharge after an admission to a medical facility
- ☐ While the client is staying near the hospital, as instructed, after surgery or during extended out-patient treatment
- ☐ This client will require a non-medical escort from ____/____/____ (yyyy/mm/dd) to ____/____/____ (yyyy/mm/dd)
- ☐ Long Term: To be reassessed by NIHB every year with an updated non-medical escort request submitted by a treating health professional

SECTION 3: AIR TRAVEL:

Requests for travel by air may be approved, following a treating health professional's **request** only when there is a medical requirement.

As a health professional, I have assessed this client specifically in relation to his/her fitness to travel by car or bus

- ☐ Could the client travel alone by car or bus?
- ☐ Could the client travel by car or bus if there was a non-medical escort travelling with him/her?
- ☐ Is air travel medically necessary due to significant medical risks from road travel?

SECTION 4: TRAVEL BEYOND THE NEAREST APPROPRIATE HEALTH FACILITY :

Requests for travel beyond the nearest facility within the Atlantic Region may be approved, following a treating health professional's **request** only when there is a medical requirement. Out of region requests maybe require additional information.

As a health professional

- ☐ I certify that this is the closest appropriate provider, given the specialty/sub-specialty required

SECTION 5: Health Professional Signature (MUST BE COMPLETED)

Health Professional Name (please print):_____Telephone Number: (____)_____

Health Professional Address:_____

Health Professional Signature:_____Date:_____

Fax this completed form to: Non-Insured Health Benefits, Atlantic Regional Office, Fax 1-866-963-7700