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

NIHB Travel Authorization Number:					-			-					

Section 1 - Client Information (client receiving the service)

Client's Full Name:____________________

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

Client's Home Address:____________________ Phone Number: (_____)__________

City: __________ Prov: _______ Postal Code: ________ Email: ____________________

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 (please add ID# if applicable): ____________________

Mailing Address (if different from home address listed above):____________________

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:_____/_____/_____ (yyyy/mm/dd) 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**	
	COB Paid	**NIHB Amount to be Paid**
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: $_______		
ACCOMMODATIONS: For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached. Private accommodations: $13.50/night per person $ ____________ Total Accommodations Claimed		
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 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

NIHB 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 NIHB, 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: ____/____/______
yyyy/mm/dd

(Signature is mandatory. Clients must sign unless they are under the age of 16 or have a medical condition prohibiting them from doing so, in which case the parent / legal guardian must sign)

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
Your authorization is also required 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 our website: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php.