

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 pre-approval and TA number. Please contact Howard Thistle (see contact information below) for further detail.
- 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 email to nlavers@qalipu.ca
- 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 Howard Thistle at 1-844-675-5743 or e-mail him at hthistle@qalipu.ca
- For general inquiries regarding medical transportation call 1-844-207-9718.

Supporting Documents:

- Click here to access the [Medical Transportation Reimbursement form](#)
- 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 **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. Faxed claims will NOT be accepted.

Call for prior approval toll-free at 1-855-675-5743

NIHB Travel Authorization Number:						-			-					
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Section 1 - Client Information (client receiving the service)

Client's Full Name: _____

Date of Birth: ____ / ____ / ____
dd / mm / yyyy

Band Registration #: _____

Clients Home Address: _____ Phone Number: (____) _____

City: _____ Prov: _____ Postal Code: _____

Non-Medical Escorts 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: _____

Mailing 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 Non-Insured Health Benefits for medical transportation.

Did you travel past the nearest health facility? Yes ☐ No ☐ (If yes, please provide medical justification)

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**): _____

Section 4 - Claim Information

Please check all that apply.	For Internal use only	
<input type="checkbox"/> TRANSPORTATION: Receipts for fuel are not required Original itemized receipt(s) must be attached for the following items: Tolls: \$_____ Bridge: \$_____ Parking: \$_____ Other: \$_____ <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	COB Paid	Amount to be Paid
<input type="checkbox"/> ACCOMMODATIONS: For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached. Private accommodations: \$13.50/night per person <input type="checkbox"/> <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>		
<input type="checkbox"/> 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 <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>		
	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:** _____ **DATE:** ____ / ____ / ____
 (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:
 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: <http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb->

1. Appointment Date: ____/____/____ Appointment Time in: _____ Appointment Time out: _____
yyyy/ mm/ dd

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

Name and Address of Health Facility: _____

Signature/Stamp from Health Facility (Mandatory): _____

2. Appointment Date: ____/____/____ Appointment Time in: _____ Appointment Time out: _____
yyyy/ mm/ dd

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

Name and Address of Health Facility: _____

Signature/Stamp from Health Facility (Mandatory): _____

3. Appointment Date: ____/____/____ Appointment Time in: _____ Appointment Time out: _____
yyyy/ mm/ dd

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

Name and Address of Health Facility: _____

Signature/Stamp from Health Facility (Mandatory): _____

4. Appointment Date: ____/____/____ Appointment Time in: _____ Appointment Time out: _____
yyyy/ mm/ dd

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

Name and Address of Health Facility: _____

Signature/Stamp from Health Facility (Mandatory): _____

5. Appointment Date: ____/____/____ Appointment Time in: _____ Appointment Time out: _____
yyyy/ mm/ dd

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

Name and Address of Health Facility: _____

Signature/Stamp from Health Facility (Mandatory): _____
