

**MEDICAL TRANSPORTATION ASSISTANCE PROGRAM
APPLICATION FOR 50% PRE-PAYMENT OF ECONOMY AIRFARE**

PATIENT INFORMATION		To Be Completed By The Patient	
Surname	First Name		
Home Address		Telephone Number	
City / Town	Province	Postal Code	
Mailing Address (if different from home address)			
City / Town		Province	Postal Code
Date of Birth (YYYY/MM/DD)	MCP Number	Expiry Date (YYYY/MM/DD)	
Do you have private health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide name of Insurance Company	
Date(s) of Appointment(s)			
If Escort is Required - Surname and First Name of Escort		Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (explain)	

REFERRING PHYSICIAN		To Be Completed By The Referring Physician/Specialized Physician	
Surname	First Name		
Address			
Telephone Number	Facsimile Number	Signature	Date (YYYY/MM/DD)
Primary Diagnosis			
Insured Service(s) Required			
Name and Address of Hospital/Physician to Whom This Patient Is Being Referred			
Escort Required <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Escort		
OUT-OF-PROVINCE MEDICAL TRAVEL REQUIRES A COPY OF THE LETTER OF MEDICAL REFERRAL FROM THE IN-PROVINCE SPECIALIST TO THE MEDICAL CONSULTANT IN THE OTHER PROVINCE			

DECLARATION OF ELIGIBILITY	
<p>I declare that the information provided on this application is true and correct to the best of my knowledge. I understand that this information will be used to determine eligibility for 50% pre-payment of economy airfare in accordance with the Medical Transportation Assistance Program criteria and conditions. I declare that financial assistance for medical travel will not be provided by the Department of Advanced Education and Skills, Workplace Health, Safety & Compensation Commission, or any other Federal/Provincial Government Department, Agency, Board, Commission, or Regional Health Authority. I understand and agree that the information I submit may be subject to verification by officials of the Department of Health and Community Services and that medical travel assistance provided to me in error is subject to recovery by the Department of Health and Community Services.</p> <p>I authorize the Department of Health and Community Services to contact and share information with the Department of Advanced Education and Skills and/or any other parties identified in this application for the purpose of verifying eligible expenses and for auditing purposes. I authorize the Department of Advanced Education and Skills and/or any other parties identified in this Declaration of Eligibility to release the requested program-related information to the Department of Health and Community Services.</p> <p>I agree to submit a completed <i>Claim for Airfare and Purchased Registered Accommodations</i> form after my medical travel has concluded. I am aware that if assessment of my claim results in an overpayment, the Department may seek to recover that amount including but not limited to any future claim I or any other family member residing in the same household might submit under the Medical Transportation Assistance Program.</p>	
<p style="text-align: center;">_____</p> <p style="text-align: center;">Signature of Claimant</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Date</p>
<p>50% PREPAYMENT IS BEING REQUESTED FOR: <input type="checkbox"/> PATIENT ONLY <input type="checkbox"/> PATIENT AND ESCORT <input type="checkbox"/> ESCORT ONLY</p> <p>TRAVEL REQUIREMENTS ARE: <input type="checkbox"/> ONE-WAY <input type="checkbox"/> RETURN TRIP</p>	