

**MEDICAL TRANSPORTATION ASSISTANCE PROGRAM
 CLAIM FOR AIRFARE AND PURCHASED REGISTERED ACCOMMODATIONS**

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)	
Date of Departure (YYYY/MM/DD)		Date of Return (YYYY/MM/DD)	
Have you made a previous claim under this Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Previous Claim (YYYY/MM/DD)	

REFERRING PHYSICIAN		To Be Completed By The Referring Physician/Specialized Physician	
Surname		First Name	
Address			
Telephone Number	Facsimile Number	Signature	Date (YYYY/MM/DD)

**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**

CLINICAL INFORMATION		To Be Completed By The Referring Physician/Specialized Physician	
Primary Diagnosis			
Insured Service(s) Required			
Name and Address of Hospital/Physician to Whom This Patient Was Referred			
Date(s) of Appointment(s)			
If In-Patient: Date of Admission (YYYY/MM/DD)		Date of Discharge (YYYY/MM/DD)	Escort Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Escort		Surname and First Name of Escort	
Address of Escort		Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (explain)	

DECLARATION OF ELIGIBILITY FOR AIRFARE AND ACCOMMODATION EXPENSES

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 reimbursement of airfare and accommodation expenses in accordance with the Medical Transportation Assistance Program criteria and conditions. I declare that financial assistance for medical travel was not 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.

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.

 Signature of Claimant

 Date