

**MEDICAL TRANSPORTATION ASSISTANCE PROGRAM
CLAIM FOR PRIVATE VEHICLE USAGE**

| CLAIMANT INFORMATION | | | To Be Completed By The Person Who Is To Receive Payment For The Private Vehicle Mileage |
|--|--------------------------|------------------|---|
| Surname | | First Name | |
| MCP Number | Expiry Date (YYYY/MM/DD) | Telephone Number | |
| Home Address | | | |
| City / Town | | Province | Postal Code |
| Mailing Address (if different from home address) | | | |
| City / Town | | Province | Postal Code |

| PATIENT INFORMATION | | | | | All Patients Listed Below Must Reside At The Same Address And Must Sign In The Space Provided to Indicate Their Consent For Payment Of Private Vehicle Mileage To Be Made Directly To The Claimant |
|----------------------------|------------|------------|--------------|--------------------------|--|
| Patient Name | | MCP Number | Expiry Date | Relationship to Claimant | Signature of Consent |
| Surname | Given Name | | (YYYY/MM/DD) | | A Parent/Guardian must sign on behalf of children under age 16 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| CLAIM INFORMATION | | | | | | Distance Travelled Will Be Calculated Based On The NL Statistics Agency Road Distance Database |
|--------------------------|---------------------|-------------------------|-------------------|----------------|------------------------------|--|
| MCP Number of Patient | Date of Appointment | Location of Appointment | Date of Departure | Date of Return | Estimated Distance Travelled | |
| | YYYY/MM/DD | City/Town | YYYY/MM/DD | YYYY/MM/DD | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

YOU MUST ATTACH WRITTEN CONFIRMATION FROM THE HEALTH CARE PROVIDER INDICATING THE DATE EACH SERVICE WAS PROVIDED AND THE SPECIALIZED SERVICE RECEIVED

DECLARATION OF ELIGIBILITY FOR PRIVATE VEHICLE USAGE

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 private vehicle 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 kilometres 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.

I declare that all patients listed reside at the same residence and have consented to payment being made to me as the claimant.

_____ Date

Signature of Claimant