Newfoundland Labrador

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? ☐ Yes ☐ No		Date of Previous Claim (YYYY/MM/DD)

REFERRING PHYSICIAN To be completed by the referring physician (for out-of province medical travel, the referral must be from a specialist physician)

Surname	First Name	
Address		
	Telephone Number	Facsimile Number

OUT-OF-PROVINCE WITHIN CANADA MEDICAL TRAVEL REQUIRES A COPY OF THE LETTER OF MEDICAL REFERRAL FROM THE IN-PROVINCE SPECIALIST TO THE MEDICAL CONSULTANT IN THE OTHER PROVINCE

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 ☐ Yes ☐ No
Reason for Escort?		
Surname and First Name of Escort		Relationship to Patient ☐ Parent ☐ Spouse ☐ Other (explain)
Address of Escort		
Physician Signature	Date (YYYY/MM/DD)	

DECLARATION OF ELIGIBILITY FOR AIRFARE AND PURCHASED REGISTERED ACCOMMODATIONS

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 that if I have private health insurance benefits, medical travel expenses must be assessed by the private insurance provider prior to submitting to the Department for assessment and that any monies paid by private insurance must be disclosed in the form of a copy of the private insurance assessment attached to the application form.

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 medical services received, 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

Medical Transportation Assistance Program Claim for Airfare and/or Purchased Registered Accommodations

Eligible Expenditures

Airfare:
Economy ticket (official ticket receipt, itinerary and boarding passes required).

Accommodations:
Up to a maximum of $125 per diem (official receipt required) when accommodations are purchased from a registered accommodations provider. After July 1, 2014 patients medically required to take up temporary residence in another region of the province or another province/territory while receiving specialized medical treatment or awaiting transplantation, can claim up to a maximum of $3,000 (official receipt required) for each period of 31 consecutive days.

The program does not have a provision for claiming for accommodations provided by family/friends.

Meal Allowance
When accommodations are purchased from a registered accommodations provider, the following meal allowance provisions apply:

- In-province to a maximum of $29 per diem per person;
- Out-of-province to a maximum of $43 per diem per person;
- The maximum meal allowance for any 31 day period is $700.

The program does not have a provision for claiming meals when accommodations are provided by family/friends.

- Patients cannot claim a meal allowance for in-patient stays.

Taxis: (when used with air travel)

- Airport to hotel/accommodations and return (official receipts required).
- Hotel/accommodations to hospital and return (official receipts required).

Scheduled Transportation Services:
such as registered busing/minivan services (official receipts required).

Submission of Claim(s)

- Claims must be submitted on a monthly basis for residents who require travel in excess of 31 consecutive days.
- Claims for duration less than 31 days must be submitted within 12 months from the travel date.

Allowable expenses will be assessed based on travel dates in relation to medical appointment/service date(s). Personal care items, utilities, and long distance telephone calls are not eligible expenses.

Redemption of Reward Points/Miles/ Vouchers

The Medical Transportation Assistance Program assists with out of pocket expenses. MTAP does not compensate for the redemption or purchase of reward points/miles/ vouchers for air tickets, claimable expenses and/ or purchased registered accommodations. However, any receipts for applicable taxes/fees or charges for the issuance of such services may be submitted to the Program for consideration under the Program's cost sharing provisions.

AIRFARE AND PURCHASED REGISTERED ACCOMMODATION CALCULATIONS

Attach additional pages if needed.

Expenses Claimed Amount

Airfare: _____ $_____
Date(s) of Travel

Taxis: _____ $_____
Date(s) of Travel
Receipts and airline travel required

Registered Accommodations:

_____ $_____
Date(s) of Travel

No. of days ____X Rate_____ $_____

Meal Allowance:
Registered Accommodations Required

No. of days ____X Rate_____ $_____

Subtotal Claimed $_____

Less: Private insurance payment $_____

Less: Deductible (if applicable) $_____

TOTAL AMOUNT CLAIMED $_____