Claim for Medical Transportation Reimbursement

It is important to submit ALL required documents and complete all sections, date and sign the claim. Please keep a copy of this form and all supporting documents for your records.

INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLEINT REIMBURSEMENT FORM

- Did you submit your original receipt(s)? Credit card/Debit (Interac) slips are not acceptable forms of proof of payment.
- Did you include confirmation of medical appointment attendance **OR** complete Section 3?
- Did you complete and sign all applicable parts of this NIHB Client Reimbursement Request Form? Forms that are unsigned or incomplete will be returned.

*Trips require **Prior Approval** by calling NIHB toll-free 1-866-606-9750, Medical Transportation Division, Extension 230 226, 246*

Section 1 – Client Information (client receiving the service)

Client's Full Name _____

Date of Birth: ____/____/____ (Day/Month/Year) Client ID # (or N#): N_____

Client's Address: _____

_____

Client's Phone Number: ____(____)_____

Escort's Name (if applicable): _____

(Medical Justification for an Escort must be provided with Claim)

Section 2 – Payment Information

All parts of this section must be completed in order for reimbursement to be paid.

Please provide the name and address of the person/facility to whom payment should be made. The payee must be over the provincial legal age of eighteen (18).

IF PAYEE INFORMATION IS THE SAME AS CLIENT INFORMATION CHECK HERE ☐

Reimbursement cheque should be made payable to: _____

Address: _____

_____

Phone Number: ____(____)_____

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Section 3 – Appointment Information

All information must be provided in order to be considered for reimbursement including the signature from the health facility. <u>You may attach a written confirmation of attendance from the health facility as an alternative to this.</u>

Appointment Date:____/___/_____ Appointment Time In:_____ Appointment Time Out:_____

Health Professional's Name: _____ Health Facility's Phone Number: (___) _____

Name and Address of Health Facility: _____

Section 4 – Claim Information

Is the health service identified in "Section 3 – Appointment Information" being covered by your provincial health plan or by the Non-Insured Health Benefits Program? Yes ____ No _____
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).

PLEASE INDICATE WHAT MEDICAL TRANSPORTATION BENEFITS ARE BEING CLAIMED, IF THIS INFORMATION IS NOT PROVIDED OR IS INCOMPLETE, THE CLAIM AND ANY ATTACHED RECEIPTS WILL BE RETURNED TO THE CLAIMANT UNPROCESSED.

☐ **TRAVEL DISTANCE**: # of Kilometers (Return Trip) _____ * $<u>0.215/km</u> = $ _____
Departing from (Community Name): _____ Arriving to (Community Name): _____
Original receipts required for ferry crossings. Mileage eligibility is 35 kilometers or more one way from home to health facility. ***We will pay no more than airfare equivalency when traveling from home community to appointments.***

☐ **ACCOMMODATIONS** *(when prior approved for trips over 600 km return)* ***Original receipt(s) for commercial accommodations must be attached, Private Accommodation will be reimbursed @ $50.00/nt. to the Claimant with claim, w/o claim the rate will be $13.50/nt.*:**

Name of Accommodation Facility: _____
Accommodations' Cost: $ _____

☐ **MEALS** *Receipts are not required as we pay per diem. Trip duration must be a minimum of three (3) hours or more in order to claim meals.* ***Please include a copy of your hotel bill, if pre-paid by NG-NIHB, when claiming for meal per diems, this will expedite the processing of your travel claim.*** *Meals will* ***not*** *be reimbursed when Private Accommodation(s) has been paid out to another Claimant.*

<u>Rate Increase Effective May 1, 2021</u>

Adult Meal Cost: Breakfast = $15.00 # _____ Lunch = $15.00 # _____ Dinner/Supper = $30.00 # _____
Child (<5 years old) Meal Cost: Breakfast = $7.50 # _____ Lunch = $7.50 # _____ Dinner/Supper = $15.00 # _____
Total Meal Cost being claimed: $ _____
Please attach a separate sheet explaining your claim in greater detail or if additional space is required.

Section 5 – Authorization and Signature

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to NIHB – NG, its agents or contractors, or any other appropriate health professional licensing or regulatory body for the purpose of an administrative audit. I declare that the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by NIHB - NG or by any other plan(s)/program(s) that is noted in the statement or explanations of benefits.

Patient's Signature: _____ **Date:** _____/_____/_____
Day/Month/Year

(*This signature is mandatory. If the client is under the age of 16, then the parent/legal guardian must sign)*

Mail this completed form along with receipt(s) (if applicable) to:
Non-Insured Health Benefits (NIHB), Medical Transportation Division,218 Kelland Drive, P.O. Box 496, Station C, Goose Bay, N.L., A0P-1C0 or by Fax: 1-709-896-9761 (original receipts must be l mailed in, if applicable)