Medical Transportation Reimbursement Form - Atlantic Region

All requests for reimbursement of eligible benefits must be made **within one year from the date of service**.
Please submit ALL required documents and keep a copy of this form with all supporting documents for your records.
Forms that are unsigned or incomplete will be returned.

Call NIHB for prior approval toll-free at 1-800-565-3294

NIHB Travel Authorization Number:					-			-					

Section 1 - Client Information (client receiving the service)

Client's Full Name:______________________________

Date of Birth:_____/_____/_____ (yyyy/mm/dd) Client ID # :______________________

Client's Home Address:______________________ Phone Number: (____)__________

City: ____________ Prov: ______ Postal Code: ______ Email: ____________

Non-Medical Escort's Name (requires prior approval unless client is a minor): ______________

Escort ID# (if applicable): ______________________

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).

Section 2 - Payment Information

Please provide the name and address of the person or organization to which payment should be made. The payee must be the provincial legal age.
IF PAYEE INFORMATION IS THE SAME AS THE CLIENT INFORMATION CHECK HERE

Cheque payable to (please add ID# if applicable): ______________________

Mailing Address (if different from home address listed above):______________________

City: ______________ Prov: ______ Postal Code: __________

Section 3 - Appointment Information

Confirmation of attendance **must be completed** OR a confirmation from the health facility attached. See page 3 for additional confirmations. **Include the name of the Health Professional seen or the type of diagnostic test performed.** Medical justification is required when travel is beyond the nearest facility. The appointment service must be insured by your provincial health plan (MCP, MSI, NB Medicare, PEI Medicare) or NIHB for medical transportation.

Appointment Date:_____/_____/_____ (yyyy/mm/dd) Appointment Time in:__________ Appointment Time out__________

Physician/Health Professional's Name:______________________ *(print)* Phone Number:(____)__________

Name and Address of Health Facility:______________________

Signature or stamp from Health Facility (**mandatory**): ______________________

Section 4 - Claim Information

Please check all that apply.	**For NIHB Internal use only**	
	COB Paid (office use only)	**NIHB Amount to be Paid**
TRANSPORTATION: Receipts for fuel are not required # of Kilometres travelled (return trip) x NIHB rate = Total Claimed __________km x $__________ = $_________ Total Transportation Claimed Original itemized receipt(s) must be attached for the following items: Tolls: $________ Bridge: $_______ Parking: $________ Other: $________		
ACCOMMODATIONS: For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached. Private accommodations: $13.50/night per person $ _____________ Total Accommodations Claimed		
MEALS: Approved if travel time away from home is over 6 hours (receipts are not required). NIHB Daily Rates: Breakfast $12 Lunch $12 Dinner $24 Rates are half for children under 5 years of age NIHB Weekly Rates (5 days or more): $168/week for one person $252/week for two people Total # Adult Meals Claimed: Breakfast ______ Lunch______ Dinner_____ Total # Child Meals Claimed: Breakfast ______ Lunch______ Dinner_____ $ _____________ Total Meals Claimed		
Total $: ____________	**Analyst:**	**Total $:**

Section 5 - Authorization and Signature

NIHB requires your authorization in order to collect information from your medical provider (including confirmation of appointment attendance) for services provided to you.

I authorize the release of any records that are relevant to the processing and payment of this claim to NIHB, it's agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by Health Canada or by any other plan(s)/program(s) that is noted in the statement or explanations of benefits.

PRINT NAME: ___________________________SIGNATURE:_________________________DATE: ____/____/_______
yyyy/mm/dd

(Signature is mandatory. Clients must sign unless they are under the age of 16 or have a medical condition prohibiting them from doing so, in which case the parent / legal guardian must sign)

Mail this completed form along with receipts (if applicable) to:
First Nations & Inuit Health Branch, Non-Insured Health Benefits
40 Havelock St, PO Box 160, Amherst, NS B4H 3Z3
Email: nihb-atlfnihb@sac-isc.gc.ca
Fax: 1-866-963-7700 (only when original receipts are not required)

Privacy statement
Your authorization is also required in order to collect information from your medical provider for services provided to you and paid for by the Non-Insured Health Benefits Program. The NIHB Program is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the NIHB Program collects, uses, discloses and retains your personal information in accordance with the applicable federal privacy laws and policies. Further details of the NIHB Privacy Code can be found on our website: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php.