

NIHB Medical Transportation Client Reimbursement Form

Instructions:

- You have one year from the date the service(s) was provided to apply for reimbursement.
- Remember to include your Band registration (or identification) number.
- Ensure you have **signed** and completed all sections of your reimbursement form and included all necessary documents, or your claim will be returned to you.
- Original receipts are required, therefore faxed copies of your claim will not be accepted.
- If you have received prior-approval for your medical trip, please be sure to include the Travel Authorization (TA) number in your claim.
 - Note: TA numbers are only valid for one trip. The next trip you take will require a new preapproval and TA number. Please contact Howard Thistle (see contact information below) for further detail.
- If you are required to travel beyond the nearest health facility, medical justification will be needed.
 Medical Justification explains why you had to travel past the nearest Health Facility for your medical needs.
 - You may have your **health care provider** complete the Benefit Exception Request Form (see link below) and submit this form with your claim.
- Sign up for Electronic Funds Transfer (EFT) to receive your reimbursement.
 - Complete the Electronic Funds Transfer Form (see link below) and mail it to the address below or call 709-634-0996 to speak to a Support Specialist to discuss emailing it in.
- All Medical Transportation reimbursement claims must be mailed to the Corner Brook office at:

NIHB Medical Transportation Program 3 Church Street Corner Brook, NL A2H 2Z4

Contact Information:

- To set up a pre-approval for your medical transportation requirement please call 709-634-0996 to speak to a Support Specialist.
- For general inquiries regarding medical transportation call 709-634-0996 to speak to a Support Specialist.

Supporting Documents:

- Click here to access the Benefit Exception Request Form
- Click here to access the EFT Direct Deposit Form

Note: The documents listed below can also be found on http://qalipu.ca/health/non-insured-health-benefits/ or at your local band office.



Medical Transportation Reimbursement Form – Qalipu First Nation

All requests for reimbursement of eligible benefits must be made <u>within one year from the date of service</u>. 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. Faxed claims will <u>NOT</u> be accepted.

Call for prior approval toll-free	at 1-8	355-67	5-57	43							
NIHB Travel Authorization Number:				•			-				
Section 1 - Client Information (clie	nt re	eceivi	ng t	he s	ervi	ice)					
Client's Full Name:											
Date of Birth: / / dd / mm / yyyy	Band	l Regis	tratio	on #:							
Clients Home Address:				P	hone	Nu	mbe	er: <u>(</u>)	1	
City: Prov: Postal Code:											
Non-Medical Escorts Name (requires prior approval unless client	is a r	ninor):									
Escort ID# (if applicable):											
Are you covered for any of these expenses under any other half YES, please attach a copy of a detailed statement or explanation											
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:											
Mailing Address:											
City: Pro	ov: _					Pos	tal C	Code	e: _		
Section 3 - Appointment Confirmation of attendance must be completed OR a confirmational confirmations. Include the name of the Health Professer performed. Medical justification is required when travel is beyon be insured by your provincial health plan (MCP, MSI, NB Medical medical transportation.	ion fi ssio id the	rom the nal se e neare	e hea en o est fa	alth f r the acility	typ /. Th	e of e ap	dia poin	gnc ntme	stice ent s	test ervic	: e must
Did you travel past the nearest health facility? Yes No] (If <u>y</u>	yes, pl	ease	pro	ovide	e me	dica	al ju	ustif	icati	on)
Appointment Date: / / Appointment Time in:			Ар	poin	tmer	nt Tir	me c	out_			
Physician/Health Professional's Name:				P	hone	Nu	mbe	er : <u>(</u>)	1	
(print) Name and Address of Health Facility:											
Signature or stamp from Health Facility (mandatory):											



Section 4 - Claim Informa	ation				
Please check all that apply.	For Internal use only				
TRANSPORTATION: Receipts for fuel are not required	COB Paid	Amount to be Paid			
Original itemized receipt(s) must be attached for the following items:					
Tolls: \$ Bridge: \$ Parking: \$ Other: \$					
For office use only:					
ACCOMMODATIONS: For trips over 600 km return, original itemized receipt(s) for commercial accommodations must be attached.					
Private accommodations: \$13.50/night per person					
For office use only:					
MEALS: Approved if travel time away from home is over 6 hours (receipts are not required).					
NIHB Daily Rates: Breakfast \$15 Lunch \$15 Dinner \$30 Rates are half for children under 3 years of age (inclusive)					
NIHB Weekly Rates (5 days or more): \$168/week for one person \$252/week for two people					
For office use only:					
	Analyst:	Total \$			
Section 5 - Authorization and	Signature				
Health Canada requires your authorization in order to collect information from your medica attendance) for services provided to you. I authorize the release of any records that are rel Canada, it's agents or contractors, or any appropriate Health Professional licensing or Reg declare the information to be true and accurate and does not contain a claim for any benef other plan(s)/program(s) that is noted in the statement or explanations of benefits.	evant to the processing julatory Body for the pu	and payment of this claim to Health rpose of administrative audit. I			
PRINT NAME:SIGNATURE:(Signature is mandatory. If client is under the age of 16, then the pare	ont / logal augratic	DATE: _ / /_			
		iii iiiust sigii) aa / mm / yyyy			
Mail this completed form along with receipts (i Qalipu Mi'kmaq First Nation Ban					

3 Church Street Corner Brook, NL A2H 2Z4

Faxed claims will be returned, and a mailed copy will be requested

Privacy statement

Health Canada also requires your authorization 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 the Health Canada website: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-



1.	Appointment Date:/ Appointment Time in:	Appointment Time out:
	yyyy/ mm/ dd	
	Physician/Health Professional's Name:(print)	Phone Number: (_)
	(print) Name and Address of Health Facility:	
	Signature/Stamp from Health Facility (Mandatory):	
2.	Appointment Date:/Appointment Time in: yyyy/ mm/ dd	Appointment Time out:
	yyyy/ mm/ dd Physician/Health Professional's Name:	Phone Number: ()
	Physician/Health Professional's Name:(print) Name and Address of Health Facility:	,
	Signature/Stamp from Health Facility (Mandatory):	
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3.	Appointment Date:// Appointment Time in:	Appointment Time out:
	yyyy/ mm/ dd	
	Physician/Health Professional's Name:(print)	Pnone Number: (_)
	Name and Address of Health Facility:	
	Signature/Stamp from Health Facility (Mandatory):	
4.	Appointment Date://Appointment Time in:	Appointment Time out:
	yyyy/ mm/ dd Physician/Health Professional's Name:	Phone Number: ()
	Physician/Health Professional's Name:(print) Name and Address of Health Facility:	
	·	
	Signature/Stamp from Health Facility (Mandatory):	
F	Appointment Date:	Appointment Time a sut
5.	Appointment Date:/ Appointment Time in: yyyy/ mm/ dd	Appointment Time out:
	Physician/Health Professional's Name:(print)	Phone Number: (_)
	Name and Address of Health Facility:	
	Signature/Stamp from Health Facility (Mandatory):	