



MEDICAL TRAVEL SUBSIDY

In-territory Out-of-territory

Patient must return completed form to Medical Travel.

Secure drop box

Deposit this form in the secure drop box at Erik Nielsen Whitehorse International Airport or Whitehorse General Hospital.

Drop off

4th floor, Financial Plaza Building
204 Lambert Street
Whitehorse, Yukon

Mail

Medical Travel
Health Services, H-2
Box 2703, Whitehorse, YT, Y1A 2C6

Email: medicaltravel@yukon.ca
Phone: 867-667-5203 or 867-667-5233 (can call collect)
Fax: 867-393-6486

The purpose of the subsidy is to assist patients with expenses while they are receiving outpatient medical care. Payments will be made to the patient and/or their escort. No receipts are required.

A parent is eligible for a subsidy while their child is admitted into a hospital.

Patients receiving long-term outpatient care can fax or email this form to us weekly. It will be processed as soon as it is received.

Patient information

| | | | |
|---|------------------------------|--------------------------------------|--|
| Full name (first, middle initial, last) | | Yukon Health Care Number 00 _____ | |
| Travel by: <input type="checkbox"/> Air <input type="checkbox"/> Road | Departure date YYYY/MM/DD | Return date YYYY/MM/DD | |
| Travel from: _____ to: _____ | | | |

Confirmation of medical services

| Medical service received | If in and out same day | If admitted overnight or multiday | | Hospital or clinic | Verification signature (doctor, nurse, technician) |
|---|------------------------|-----------------------------------|----------------|-----------------------|--|
| | Appointment date | Admission date | Discharge date | | |
| Examples: Total hip replacement | YYYY/MM/DD | 2019/01/21 | 2019/01/28 | Royal Columbian Hosp. | Signature |
| MRI | 2019/01/30 | YYYY/MM/DD | YYYY/MM/DD | Whse General Hosp. | Signature |
| | YYYY/MM/DD | YYYY/MM/DD | YYYY/MM/DD | | |
| | YYYY/MM/DD | YYYY/MM/DD | YYYY/MM/DD | | |
| | YYYY/MM/DD | YYYY/MM/DD | YYYY/MM/DD | | |
| | YYYY/MM/DD | YYYY/MM/DD | YYYY/MM/DD | | |
| | YYYY/MM/DD | YYYY/MM/DD | YYYY/MM/DD | | |

Make subsidy cheque payable to Patient Escort Separate cheques

| | |
|-----------------------------------|-------|
| Full name of patient | Phone |
| Address | |
| Full name of escort (if approved) | Phone |
| Address | |

Signature

Is this a WCHSB-related injury? Yes No

Do you have insurance coverage from one of the following? Yes – check all that apply No

RCMP Status First Nation Canada Post Federal government (e.g. Parks Canada/DFO)

I verify that the information contained on this form is true to the best of my knowledge.

Signature of patient or guardian

Date

OFFICE USE ONLY

| Patient subsidy | | | | | | | |
|-----------------|----|----|----|----|----|----|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | _____ days @ \$_____ / day = _____ .00 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 | _____ days @ \$_____ / day = _____ .00 |
| Escort subsidy | | | | | | | |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 | _____ days @ \$_____ / day = _____ .00 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 | _____ days @ \$_____ / day = _____ .00 |
| 29 | 30 | 31 | | | | | |

Information contained in this form is collected, used and disclosed in accordance with Yukon's Health Information Privacy and Management Act and other applicable laws. A written statement of Health and Social Services information practices can viewed at www.hss.gov.yk.ca/healthprivacy.php or by contacting the department's Privacy Officer at healthprivacy@yukon.ca