

R. 06/11/03

**Medical Transportation Assistance Program**

**Part 1 - Must be completed by Referring Physician/Specialized Physician (PLEASE PRINT)**

**Patient Information**

Name of Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 (First) (Middle) (Last) (home) (work)  
 Address: \_\_\_\_\_  
 (Mailing Address) (City) (Postal Code)  
 Date of Birth: \_\_\_\_\_ MCP Number: \_\_\_\_\_  
 (year/month/day) Date of Departure: \_\_\_\_\_  
 Social Insurance Number: \_\_\_\_\_ Date of Return: \_\_\_\_\_  
 (If patient is a child, please provide parent/guardian's number)

**Clinical Information**

Primary Diagnosis: \_\_\_\_\_

Name and Address of Hospital and/or Physician to Whom This Patient Was Referred:  
 \_\_\_\_\_

Insured Service(s) required: \_\_\_\_\_

Date(s) of appointment(s): \_\_\_\_\_

If in-patient: Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

**Out-of-Province medical travel requires a copy of the letter of medical referral from the in-province specialist to the medical consultant in the other province.**

Escort Required:  YES  NO

State Reason for Escort \_\_\_\_\_

Name & Address of Escort \_\_\_\_\_

Escort's Social Insurance Number: \_\_\_\_\_

Relationship to Patient: Parent  Guardian  Spouse  Other

**Referring Physician**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date Completed \_\_\_\_\_

*(Signature of Referring Physician)*

**Part II - Declaration of Eligibility**

*I hereby make application for reimbursement of medical travel costs in accordance with the Medical Transportation Assistance Program criteria and conditions on the reverse side of this application. As required, original receipts and supporting documentation are enclosed. I declare that financial assistance for medical travel was not provided by the Department of Human Resources, Labour and Employment or any other Federal and/or Provincial Government Department, Agency, or Regional Integrated Health Authority. I have disclosed any payments made by Private Health Insurance as part of this claim. I hereby consent that the Department of Health and Community Services may contact the Department of Human Resources, Labour and Employment and/or any other parties identified in the Declaration of Eligibility Section for verification of eligibility for medical travel assistance. I authorized the Department of Human Resources, Labour and Employment and/or any other parties identified in the Declaration of Eligibility to release the requested information to the Department of Health and Community Services.*

**State date(s) of any prior claim(s) made under the Medical Transportation Assistance Program.**

\_\_\_\_\_  
*Signature of applicant*  
*(If other than patient, please state relationship to patient)*

\_\_\_\_\_  
*Application Date*

**WHO QUALIFIES**

**Effective February 1, 2006**

Residents of Newfoundland and Labrador who travel **commercial air and/or by private vehicle for distance greater than 200 km (one way)** to access medically necessary insured services:

- within the province when an insured service is not available in the area of residence; and
- outside the province when an insured service is not available within the province.
- escort as recommended by the referring physician
- private vehicle expense, such as gas, car mileage are not claimable under this program

**Medical Referrals**

In Province

- in-province medical travel requires referral of a physician

Out-of-Province - Within Canada

- out-of-province medical travel requires referral of a specialized physician and **copy of supporting medical referral** to the Medical Consultant within Canada.

Out-of-Country

- out-of-country medical travel requires that the referring specialized physician must seek Prior Approval from the Medical Care Plan.

**Excluded Persons**

- Income Support Recipients as eligible medical travel costs maybe funded through the Department of Human Resources, Labour & Employment
- Bone Marrow/Stem Cell and Organ Donors are eligible for financial assistance through the Eastern Regional Integrated Health Authority
- Persons who receive Medical Travel Assistance from Federal and/or Provincial Government Department(s), Agency(s), Regional Integrated Health Authority(s).

**ELIGIBLE EXPENDITURES**

**The following allowable expenses are cost shared at 50% (after the applicable deductible):**

**Airfare**

- cost of ticket (official ticket receipt and boarding passes required)

**Accommodations**

- up to a maximum of \$75 per diem (official receipt required) when accommodations are provided by a registered accommodations provider.
- patients medically required to take up residence in another region of the province or another province/territory while receiving specialized medical treatment or awaiting transplantation shall claim up to a maximum of \$1,000 (official receipt required) for each period of 31 consecutive days
- if an escort is required, the escort is expected to share the same accommodations as the medically referred person unless the medically referred person is hospitalized.

Registered accommodations provider would be a hostel, hotel, motel and/or a licensed apartment provider, such as an apartment building.

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

**Meal Allowance**

When accommodations are provided by 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
- patients medically required to take up residence in another area of the province or another province/territory while receiving specialized medical treatment or awaiting transplantation shall claim up to a maximum of \$650 for each period of 31 consecutive days.
- if an escort is required to accompany a patient while residing in another area of the province or another province/territory; the escort's maximum meal allowance is \$650 for each period of 31 consecutive days.

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

**Taxis**

- airport to registered accommodations provider and return (official receipts required)
- registered accommodations provider to hospital and return (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.

**HOW DOES THE PROGRAM WORK**

- if the patient has private health insurance benefits, claims for this program, must be assessed by the private insurance prior to submitting to the Department for assessment. Please attach a copy of the private travel assessment with your application form.
- eligible expenses under the program will be reduced by the amount paid by the private insurance plan prior to assessment under this Program. The balance of eligible expenses will be assessed based on the criteria/guidelines of the Program.
- \$500 deductible in any 12 month period from the date of the initial travel for residents on the island portion of the province with the balance of remaining claimable expenditures cost shared at 50%.
- payment of first \$500 in any 12 month period from the date of the initial travel for Labrador residents with the balance of remaining claimable expenditures cost shared at 50%.
- patients are required to pay medical travel costs and make application for reimbursement of allowable expenses.
- The Department of Health and Community Services will not make pre-payment arrangements.
- applicants must provide official receipts for allowable expenses.
- The Department may request an applicant to seek prior approval if additional medical travel is required as follow up to the initial medical travel claim.
- applications are assessed in relation to Doctor appointment(s) and/or treatment date(s)

***Allowable expenses will be assessed based on travel dates in relation to medical appointment/service date(s)***

***Personal care items and long distance telephone calls are not eligible expenses***

**Website: [www.health.gov.nl.ca/mcp/html/forms.htm](http://www.health.gov.nl.ca/mcp/html/forms.htm)  
Email: [francinasweetapple@gov.nl.ca](mailto:francinasweetapple@gov.nl.ca)**

<b>Expenses Claimed</b>	<b>Amounts</b>
Airfare:	\$ _____
Dates: _____	
Registered Accommodations:	\$ _____
Dates: _____	
(Number of days x rate)	
Meals Allowance:	\$ _____
(based on registered accommodations)	
Dates: _____	
(Number of days x rate)	
Taxis:	\$ _____
Dates: _____	
Subtotal Claimed	\$ _____
Less: Private Insurance payment	\$ _____
Less: Deductible(if applicable)	\$ _____
<b>Total Amount Claimed</b>	<b>\$ _____</b>