MEDICAL TRANSPORTATION ASSISTANCE PROGRAM

APPLICATION FOR PRE-PAYMENT OF ECONOMY AIRFARE

Newfoundland & Labrador

PATIENT INFORMATION — To Be Completed By The Patient

Surname	First Name	
Home Address		Telephone Number
City / Town	Province	Postal Code
Mailing Address (if different from home address)		
City / Town	Province	Postal Code
Date of Birth (YYYY/MM/DD)	MCP Number	Expiry Date (YYYY/MM/DD)
Do you have private health insurance? ☐ Yes ☐ No	If yes, please provide name of Insurance Company	
Date(s) of Appointment(s)		
If Escort is Required - Surname and First Name of Escort	Relationship to Patient ☐ Parent ☐ Spouse ☐ Other (explain)	

REFERRING PHYSICIAN — To be completed by the referring physician (for out-of province medical travel, the referral must be from a specialist physician)

Surname		First Name	
Address			
Telephone Number	Facsimile Number	Signature	Date (YYYY/MM/DD)
Primary Diagnosis			
Insured Service(s) Required			
Name and Address of Hospital/Physician to Whom This Patient Is Being Referred			
Escort Required ☐ Yes ☐ No	Reason for Escort		

OUT-OF-PROVINCE / WITHIN CANADA MEDICAL TRAVEL REQUIRES A COPY OF THE LETTER OF MEDICAL REFERRAL FROM THE IN-PROVINCE SPECIALIST TO THE MEDICAL CONSULTANT IN THE OTHER PROVINCE

DECLARATION OF ELIGIBILITY

- I declare that the information provided on this application is true and correct to the best of my knowledge. I understand that this information will be used to determine eligibility for reimbursement of airfare and accommodation expenses in accordance with the Medical Transportation Assistance Program criteria and conditions.
- I declare that financial assistance for medical travel was not provided by the Department of Immigration, Skills & Labour, Workplace Health, Safety & Compensation Commission, or any other Federal/Provincial Government Department, Agency, Board, Commission, or Regional Health Authority.
- I understand that if I have private health insurance benefits, any monies paid by private insurance must be disclosed in the form of a copy of the private insurance assessment attached to the application form.
- I understand and agree that the information I submit may be subject to verification by officials of the Department of Labrador Affairs and that medical travel assistance provided to me in error is subject to recovery by the Labrador Affairs.
- I authorize the Department of Labrador Affairs to contact and share information with the Department of Immigration, Skills & Labour and/or any other parties identified in this application for the purpose of verifying medical services received, eligible expenses and for auditing purposes.
- I authorize the Department of Immigration, Skills & Labour and/or any other parties identified in this Declaration of Eligibility to release the requested program-related information to the Department of Labrador Affairs.

Signature of Claimant _____ Date _____

50% PREPAYMENT IS BEING REQUESTED FOR: ☐ **PATIENT ONLY** ☐ **PATIENT AND ESCORT** ☐ **ESCORT ONLY**

TRAVEL REQUIREMENTS ARE: ☐ **ONE-WAY** ☐ **RETURN TRIP**