



**Section 4: Details of Medical Travel** – Please complete applicable sections below and provide receipts and proof of payment, where required. Please only provide the information requested, do not include any unnecessary personal information. If you are claiming more than one trip, please attach an ELIGIBLE EXPENSES WORKSHEET available at: <https://www.gov.nl.ca/exec/las/medical-transportation-assistance-program-mtap/>, to ensure prompt review ensure each trip and associated supporting documentation is clearly identified by TRIP #.

**Trip 1**

Date of Departure (YYYY/MM/DD):

Date of Return (YYYY/MM/DD):

Patient Number (From Section 2)	Appointment Location	Date of Appointment YYYY/MM/DD	Name of Specialist	Primary Diagnosis	Insured Service Required	Reason for Travel <sup>1</sup>

<sup>1</sup> Reasons for Travel can include Specialist Appointments, Treatments (e.g. Cancer/Dialysis), and Specialized Testing.

Did either of the above appoints include an in-patient stay? Yes  No   
 If yes, please include confirmation of the in-patient stay with your supporting documentation.

Please confirm the following expenses/receipts for patients and escorts, if applicable, have been included with your claim

Expense Type	Expense Date(s)	Expense amount	Receipts Attached	Notes
Airfare & Baggage			<input type="checkbox"/>	
Taxis			<input type="checkbox"/>	
Paid Accommodations			<input type="checkbox"/>	
Private Accommodations (\$25/night)			N/A	
Ferries, Car Rentals and Buses			<input type="checkbox"/>	

† Meals are automatically claimed with Accommodations Total:

If you require additional space to capture your private vehicle mileage for this trip, please complete and attach a PRIVATE VEHICLE WORKSHEET available at: <https://www.gov.nl.ca/exec/las/medical-transportation-assistance-program-mtap/> to this claim.

Private Vehicle Mileage	Starting Location (e.g. City/Town/Facility)	Ending Location (e.g. City/Town/Facility)	Date(s) of Travel	Round Trip	Estimated Distance Travelled (Total of both legs if a round trip)
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
Total:					<input type="text"/>

Please confirm the following supporting documentation, if applicable, has been included with your claim

- Document Type: Travel Itinerary (i.e. flights)  Confirmation of Attendance  Medical Support for Escort   
 for Each Appointment
- Confirmation of In-Patient Stay  All Expense Receipts Included

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**Section 5: Declaration of Eligibility for Medical Transportation Assistance – The below declaration must be signed before processing of the claim can occur. Unsigned applications will be considered incomplete and will not begin the review process.**

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- I declare that the information provided on this application is true and correct to the best of my knowledge.
- I understand that this information is collected by the Department of Labrador Affairs pursuant to section 61(1)(c) of the *Access to Information and Protection of Privacy Act, 2015* as such information relates directly to and is necessary to, and will be used to determine eligibility for reimbursement of eligible expenses in accordance with the Medical Transportation Assistance Program criteria and conditions, which may include discussions with parties from the Department of Health and Community Services.
- I declare that financial assistance for medical travel was not provided by the Department of Children, Seniors and Social Development, Department of health and Community Services, Workplace NL, or any other Federal/Provincial Government Department, Agency, Board, Commission, or Regional Health Authority.
- I understand that if I have private health insurance benefits, medical travel expenses must be assessed by the private insurance provider prior to submitting a claim to the Department for assessment and that any monies paid by private insurance must be disclosed in the form of a copy of the private insurance assessment and 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 Department of Labrador Affairs.
- I authorize the Department of Labrador Affairs to contact and share information with any other parties identified in this application for the purpose of verifying medical services received, eligible kilometres and for auditing purposes.
- I authorize the Department of Children, Seniors and Social Development and/or any other parties identified in this Declaration of Eligibility to release the requested program-related information to the Department of Labrador Affairs.

**Claimant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Completed claims, along with the required supporting documentation and official receipts for eligible costs can be emailed to: [mtap@gov.nl.ca](mailto:mtap@gov.nl.ca) or sent by Fax to 709-729-1918.

Alternatively, a patient or claimant can mail their claim and support to the following:

**Medical Transportation Assistance Program  
Department of Labrador Affairs  
Government of Newfoundland and Labrador  
P.O. Box 8700, St. John's, NL A1B 4J6**