

MEDICAL TRANSPORTATION ASSISTANCE PROGRAM OUT OF PROVINCE MEDICAL TRANSPORTATION ASSISTANCE CLAIM

Section 1: Claimant Information – Provide the information of the claimant (patient, parent, guardian, escort, etc.) to whom payment should be made.

Last name:		F	irst Name:	Pho		Phone Number:			
MCP#			MCP Expiry Date:		Date o	Date of Birth:			
Residential Address:			City/Town:		Provin	Province:		Postal Code:	
Mailing Address (If different):				City/Town:	Provin	Province:		Postal Code:	
Email:				Preferred Contac	ct Method: E	mail 🗆	Phone □	Mail □	
′es □	ave health insurance No ☐ If Yes, ravel expenses MUS	Name of Insurance	e Provider:		·			·	
lave you 'es □	ı received funding fo No □ If Yes,	or travel from any o Source:	other sources, su	ich as a travel subs Amoun	-	rofit orga	anization or w	ork etc.?	
yes, pie	ease contact Income	Support Medical	Transportation a	t 1-833-729-6106 for	r more information	n about	receiving med	dical travel	
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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** Date of **Insured Service** Appointment Number Reason for Travel¹ Appointment Name of Specialist **Primary Diagnosis** (From Location Required YYYY/MM/DD Section 2) ¹Reasons 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? 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 Date(s) Expense amount Receipts Attached Notes Expense Type Airfare & Baggage **Taxis** Paid Accommodations (\$125/night max) Private Accommodations (\$25/night) N/A Ferries, Car Rentals and Buses † 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 **Ending Location** Date(s) of Travel Round Estimated Distance Travelled (e.g. City/Town/Facility) (e.g. City/Town/Facility) Trip (Total of both legs if a round trip) П Total: 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 NL Specialist Referral Letter □ Confirmation of In-Patient All Expense Receipts Included Stav

Section 5: Referring Physician – All out-of-province medical travel within Canada requires a copy of the medical referral letter from the Newfoundland and Labrador in-province specialist to the medical provider in the other Province. A new referral must be completed for each unrelated diagnosis and/or every 12 months from date of first referral. Referring Physician Information **Last Name:** First Name: **Phone Number:** Clinic Address: City/Town: Province: **Postal Code:** Referral Details Name of Physician/Hospital to Whom This Patient Was Referred: Physician/Hospital Address: City/Town: Province: Postal Code: If In-Patient Date(s) of Appointment(s): Date of Admission: Date of Discharge: Section 6: 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. • 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 or sent by Fax to 709-729-1918.

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

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