MEDICAL TRANSPORTATION ASSISTANCE PROGRAM

ADDITIONAL TRIPS - FLIGHTS AND ACCOMMODATION WORKSHEET

CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE TO BE ELIGIBLE FOR ASSESSMENT

Additional Trip Details – Complete the applicable sections below for any additional trips being claimed on your application. Please ensure each trip and associated supporting documentation is clearly identified by Trip #.

Trip # _____

Date of Departure (YYYY/MM/DD): **Primary Reason for Travel:**

Date of Return (YYYY/MM/DD): **Condition, Illness, or Physician Specialty:**

Patient Number (From Section 2)	Appointment Location	Date of Appointment YYYY/MM/DD	Name of Specialist

Did either of the above appointments include an in-patient stay? Yes ☐ No ☐

If yes: Date of Admission: **Date of Discharge:**

Please include confirmation of the in-patient stay with your supporting documentation.

Escort Information – If applicable, provide the information of the escort. An escort must be medically required and supported by medical documentation from a physician. Please ensure that information provided is accurate.

Last Name: **First Name:** **Date of Birth:**

Relation to Patient: Parent ☐ Spouse ☐ Other:

Please confirm the following expenses/receipts for patients and escorts, if applicable, have been included with your claim. 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/la/medical-transportation-assistance-program-mtap/medical-transportation-assistance-program/ to this claim.

Expense Type	Expense Date(s)	Expense amount	Receipts Attached
Airfare & Baggage			☐
Taxis			☐
Paid Accommodations ($150/night max)			☐
Private Accommodations ($25/night)			N/A
Ferries/Buses			☐
† Meals are automatically claimed with Accommodations	Total:	$ 0.00	

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)
			☐	
			☐	
			☐	
			☐	
			Total:	0

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

Document Type: Travel Itinerary (i.e. flights) ☐ Confirmation of Attendance for Each Appointment ☐ Medical Support for Escort ☐

Confirmation of In-Patient Stay ☐ All Expense Receipts Included ☐

Trip # _____

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Date of Return (YYYY/MM/DD): **Condition, Illness, or Physician Specialty:**

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Last Name: **First Name:** **Date of Birth:**

Relation to Patient: **Parent ☐** **Spouse ☐** **Other:**

Please confirm the following expenses/receipts for patients and escorts, if applicable, have been included with your claim. 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/la/medical-transportation-assistance-program-mtap/medical-transportation-assistance-program/ **to this claim.**

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			☐	
			☐	
			☐	
			☐	

Total: 0

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

Document Type:

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

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