

Medical Transportation Assistance Program

In-Province Medical Transportation Claim

Flights and Other Travel Costs

Claims must be received within 12 months of the date of service to be reviewed

Are you using the right form?

Use this form to claim flights, hotels or other travel costs for one in-province trip.

If you are claiming private vehicle mileage only for one or more in-province trips, please use the **In-province Medical Transportation Claim - Private Vehicle Only** form available on our [website](#).

Need help filling out this form?

Check out the [user guide](#) on our website.

Section 1: Claimant Information

Last Name:	First Name:	Phone Number:	
MCP Number:	MCP Expiry Date (YYYY/MM/DD):	Date of Birth (YYYY/MM/DD):	
Residential Address:	City/Town:	Province:	Postal Code:
Mailing Address (if different):	City/Town:	Province:	Postal Code:
Email:	Preferred Contact Method: Email ☐ Phone ☐ Mail ☐		

Section 2: Patient Information

Is the above claimant also a patient? Yes ☐ No ☐

Patient					Signature of Consent
Last Name	First Name	MCP Number	MCP Expiry Date YYYY/MM/DD	Relationship to Claimant (Self/Spouse/Child)	Parent/Guardian <u>must</u> sign for children under the age of 16

* The claimant and patient(s) must reside in the same household

Does either patient have private health insurance through their employer or an insurance plan they purchased themselves (e.g., Blue Cross, Canada Life, belairdirect)? Yes ☐ No ☐

If yes, name of insurance provider:

Medical travel expenses must be reviewed by the private insurance provider before submitting this MTAP claim.

Has either patient received, or are they eligible to receive, travel support for this trip from another department, organization (e.g., Hope Air), employer, or government, including the Non-Insured Health Benefits program (NIHB)?

Yes ☐ No ☐

If yes, source:

Amount:

Is either patient receiving income support, or home support or financial benefits through the Community Support Program? Yes ☐ No ☐

If yes, please apply to the Medical Transportation Supports (MeTS) Program at 1-833-729-6106 for medical travel assistance.

Section 3: Escort Information

An escort must be medically required and supported by medical documentation from a physician or nurse practitioner.

Last Name:

First Name:

Date of Birth:

Relation to Patient: Parent ☐ Spouse ☐ Other:

Section 4: Details of Medical Travel

Date of Departure (YYYY/MM/DD):

Primary Reason for Travel:

Date of Return (YYYY/MM/DD):

Condition, Illness, or Physician Specialty:

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.

Expense Type	Expense Date(s)	Expense Amount	Receipts Attached
Airfare and Baggage			☐
Taxis or Car Rental			☐
Paid Accommodations			☐
Private Accommodations			N/A
Ferries/Buses			☐
† Meals are automatically claimed with Accommodations		Total:	\$ 0.00

Private Vehicle Mileage

Starting Location (e.g. City/Facility)	Ending Location (e.g. City/Facility)	Date(s) of Travel	Round Trip	Total Distance (Both Legs, if Round Trip)
			☐	
			☐	
			☐	
Total:				0

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

Travel Itinerary
(i.e., flights) ☐

Medical Support
for Escort ☐

Confirmation of Attendance
for Each Appointment ☐

All Expense Receipts
Included ☐

Confirmation of
In-Patient Stay ☐

Insurance Provider's Explanation
of Benefits (payout details) for
Travel ☐

Submitted Direct
Deposit Supplier
Form ☐

Section 5: Declaration of Eligibility for Medical Transportation Assistance

The claimant must sign the following declaration on page four (4). Unsigned claims are considered incomplete and will be returned for a signature. An electronic signature may be used when the claimant is the sole patient.

- I declare that the information provided on this claim 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 I am not eligible for or have not received financial assistance for medical travel from the Department of Social Supports and Well-Being, Department of Health and Community Services, Workplace NL, NL Health Services, or any other funding received from an Agency, Board, Commission, organization (e.g., Hope Air) or Provincial/Federal Government or program, including the Non-Insured Health Benefits Program.
- I understand that if I have private health insurance benefits, medical travel expenses must be reviewed by the private insurance provider before 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 claim 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 claim for the purpose of verifying medical services received, eligible kilometres, and for auditing purposes.
- I authorize the Department of Social Supports and Well-Being and/or any other parties identified in this Declaration of Eligibility to release the requested program-related information to the Department of Labrador Affairs.

I _____ hereby declare that I am the person named on this form and I am a resident of Newfoundland and Labrador. Instead of a written signature, my typed name on the form shall be considered my electronic signature.

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.

Alternatively, the claimant can mail their claim and support to:

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

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