MEDICAL TRANSPORTATION ASSISTANCE PROGRAM

IN PROVINCE MEDICAL TRANSPORTATION ASSISTANCE CLAIM

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

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

Last Name: | **First Name:** | **Phone Number:**

MCP# | **MCP Expiry Date:** YYYY/MM/DD | **Date of Birth:**

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 – All patients listed below must live at the same address of the claimant and must sign in the space provided to indicate their consent for payment of eligible expenses to the claimant.

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

Patient						Signature of Consent
Number	Last Name	First Name	MCP Number	MCP Expiry Date YYYY/MM/DD	Relationship to Claimant (Self/Spouse/Child)	Parent/Guardian must sign on behalf of children under the age of 16
1						
2						
3						
4						

Does either patient have health insurance either through work or privately purchased (i.e. Blue Cross, Canada Life, belairdirect etc.)?
Yes ☐ No ☐ If Yes, Name of Insurance Provider:
Medical travel expenses MUST be assessed by the private insurance provider prior to submitting a claim to the Department.

Has either patient received a travel subsidy from another Department, organization, or employer to help cover the cost of this trip?
Yes ☐ No ☐ If Yes, Source: Amount:

Is either patient a Subsidized Home Support recipient or in receipt of Income Support Benefits? Yes ☐ No ☐
If yes, please contact Income Support Medical Transportation at 1-833-729-6106 for more information about receiving medical travel assistance.

Section 3: 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:**

Relation to Patient: Parent ☐ Spouse ☐ Other:

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/la/medical-transportation-assistance-program-mtap/medical-transportation-assistance-program/ to ensure prompt review ensure each trip and associated supporting documentation is clearly identified by TRIP #.

Trip Details

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.

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 ☐
- Insurance Provider's Explanation of Benefits (payout details) for Travel ☐
- All Expense Receipts Included ☐

Section 5: Declaration of Eligibility for Medical Transportation Assistance – The declaration below must be signed by the claimant. Unsigned applications 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 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 NL Health Services.

• 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.

I _____ hereby declare that I am the person named on this form and I am a resident of Newfoundland and Labrador. In lieu 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, a patient or claimant can mail their claim and support to the following:

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

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