Henvey Inlet First Nation
Pickerel, ON P0G 1J0

Administration
295 Pickerel River Road
T 705-857-2331
F 705-857-3021
1-800-614-5533

Health Centre
354A Pickerel River Road
T 705-857-1221
F 705-857-0730
1-866-252-3330

Day Care
354B Pickerel River Road
T 705-857-0957
F 705-857-1369

Chief
M. Wayne McQuabbie
Council
Lionel Fox
Patrick Brennan
Carl Ashawasagai
Brenda Contin
Genevieve Solomon-Dubois
Tony Solomon

Memorandum

To: Band Members of Henvey Inlet First Nation

From: Darcy Ashawasegai-P.S.C./Reception

Date: 1/31/2017

Re: **Medical Transportation info for Off Reserve Band Members**

There are a few options for Off Reserve Band Members who are looking for assistance to attend Medical Appointments. First I would like to mention the NIHB Client Reimbursement Form, which you will find attached. The NIHB Client Reimbursement Form can be used for reimbursement of NIHB-eligible benefits and services within a year of the date of services/benefit. Please note the Non Insured Health Benefits (NIHB) policies and requirements for coverage apply. You can find this info at http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/gener-qa-qr-eng.php Please follow the instructions and information provided on the form in order to receive your reimbursement. Please note you will not receive financial help before your appointment as it will be reimbursed.

Secondly, Clients can also call Non-Insured Health Benefits themselves depending on your location. Main office is located in Ottawa the number is 1-800-881-3921 Prompts #1, then #3 for Medical Transportation. Northern Office is located in Thunder Bay 807-343-5310 and ask for Medical Transportation Prior Approvals. You will be asked to provide all your info on your appointment date, time, address of appointment, name of doctor and how you will be travelling (car/bus). This will also be reimbursed to you after your appointment.

Band Members can try to access their local Friendship Centre's, Health Centre's as some can provide you with contact info on where to get help with Medical Appointments. Clients can also be reimbursed through the Northern Ontario Travel Grant, which you can also find attached.

I would also like to mention that any clients who are on Ontario Disability or Ontario Works/ Social Services can also contact their Worker for info on how they can help with Medical appointments, bus passes, medical equipment, and as well as other services before they contact the Henvey Inlet Health Centre.

We hope you find this information helpful.

DA/

Health Canada | Santé Canada

Your health and safety... our priority. *Votre santé et votre sécurité... notre priorité.*

NIHB CLIENT REIMBURSEMENT FORM

INSTRUCTIONS

- You have **one year** from the date the services were provided to apply for reimbursement of NIHB-eligible benefits and services. Please note that all NIHB Program policies and requirements for coverage apply.
- Complete a separate NIHB Client Reimbursement form for each eligible client and type of benefit. Please do not include different types of benefits (e.g. dental, vision) on the same form.
- **Please refer to the CONTACT INFORMATION for inquiries about NIHB-eligible benefits, the status of a claim, and/or mailing address.**
- Indicate the client identification number (i.e. 'status number' for registered First Nations or 'N number' for recognized Inuit).
    - *Inuit clients*: Please note that your Territorial Health Card number *may* be used in place of your 'N number'. If you provide your 'N number, your Territorial Health Card number is not required.
    - In the case of a *child under 12 months of age who has not yet been registered/recognized*, please provide the identification number of the parent. For dental benefits, children of any age must have their own identification number.
- If the person seeking reimbursement is different from the client receiving the service (e.g. parent or guardian), please complete part 1 and part 2 of the form.
- You can obtain payment by direct deposit. For an enrolment form visit the Health Canada website http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/cfob-dgcm/ddi-ddo/index-eng.php, or email DD@hc-sc.gc.ca.

PLEASE MAKE SURE TO:

✓ **Complete and sign the NIHB Client Reimbursement Form(s)** ***(incomplete forms cannot be processed and will be returned).***
- **The signatory must be at least 16 years of age.**
- **Please provide your contact information / phone number in case the NIHB Program needs additional information in order to process your reimbursement claim.**

✓ **Provide the required supporting documents from the list below.**

✓ **Mail the completed and signed reimbursement form, along with supporting documents, to the appropriate address (see page 3).**

SUPPORTING DOCUMENTS (TO BE INCLUDED WITH YOUR COMPLETED AND SIGNED CLIENT REIMBURSEMENT FORM):

✓ Provide **original receipt(s)** as proof of payment. Receipt (s) must list client's full name, date of service, provider/office name, description of services, and proof of total amount paid.

✓ If you have other health coverage, please submit the detailed **statement or** ***explanation of benefits form*** from all other health plans(s)/program(s) as well as a **COPY of the original receipts** (your primary insurer requires the original receipts).

For Pharmacy and Vision Care claims:

✓ A copy of your prescription.

For Medical Supplies and Equipment claims:

✓ A copy of your prescription.

✓ Contact your regional office (see page 4) to confirm whether additional medical documentation is required to support your claim.

For Dental and Orthodontic Services claims:

✓ Include a copy of one of the following forms, completed and including office verification by your dental or orthodontic service provider:
- Association des Chirurgiens Dentistes du Québec Dental Claim and Treatment Plan Form
- Standard Dental Claim Form
- Canadian Association of Orthodontics Information Form

✓ Please note that you may also use the NIHB Dental Claim Form (Dent-29 Form) to submit your claim for reimbursement.

Canada

For Medical Transportation claims:

- ✓ Provide proof of your medical appointment attendance.
- ✓ Please note that you may also use a medical transportation form provided by your regional office to submit your claim for reimbursement.

CONTACT INFORMATION

For reimbursements, please mail your completed form(s) and supporting documents to the applicable Regional Office, the NIHB Drug Exception Centre, or the NIHB Dental Predetermination Centre (for dental and orthodontic services).

PHARMACY, DENTAL AND ORTHODONTIC BENEFITS:

DENTAL PREDETERMINATION CENTRE
DENTAL SERVICES
NIHB/ FNIHB
Health Canada
Address Locator 1902D
200 Eglantine Driveway, 2nd floor
Ottawa, Ontario K1A OK9
Telephone (toll-free): 1-855-618-6291
Fax: 1-855-618-6290

DENTAL PREDETERMINATION CENTRE
ORTHODONTIC SERVICES
NIHB/FNIHB
Health Canada
Address Locator 1902C
200 Eglantine Driveway, 2nd floor
Ottawa, Ontario K1A OK9
Telephone (toll-free): 1-866-227-0943
Fax: 1-866-227-0957

DRUG EXCEPTION CENTRE
CLIENT REIMBURSEMENT
NIHB/FNIHB
Health Canada
Address Locator 1902D
200 Eglantine Driveway, 2nd floor
Ottawa, Ontario K1A OK9
Please direct telephone inquiries to your Health Canada Regional office.

MEDICAL SUPPLIES AND EQUIPMENT, VISION CARE, AND MEDICAL TRANSPORTATION BENEFITS:

Alberta Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
9700 Jasper Avenue, Suite 730
Edmonton, Alberta T5J 4C3
Telephone (toll-free): 1-800-232-7301

Saskatchewan Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
2045 Broad Street, 1st Floor
Regina, Saskatchewan S4P 3T7
Telephone (toll-free): 1-866-885-3933

Manitoba Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
391 York Avenue, Suite 300
Winnipeg, Manitoba R3C 4W1
Telephone (toll-free): 1-800-665-8507

Ontario Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
Sir Charles Tupper Building
2720 Riverside Drive, 4th Floor
Mail Stop 6604E
Ottawa, Ontario K1A 0K9
Telephone (toll-free): 1-800-640-0642

Quebec Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
200 René-Lévesque Boulevard West
Guy-Favreau Complex, 2nd floor
Montréal, Québec H2Z 1X4
Telephone (toll-free): 1-877-483-1575

Atlantic Region
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1505 Barrington Street
Suite 1525, 15th Floor, Maritime Centre
Halifax, Nova Scotia B3J 3Y6
Telephone (toll-free): 1-800-565-3294

Northern Region (NWT & Nunavut)
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
Sir Charles Tupper Building
2720 Riverside Drive
Mail Stop 6604C
Ottawa, Ontario K1A 0K9 Telephone (toll-free): 1-888-332-9222

Northern Region (Yukon)
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
300 Main Street, Suite 100 Whitehorse,
Yukon Y1A 2B5
Telephone (toll-free): 1-866-362-6717

British Columbia
For Clients Eligible under the First Nations Health Authority (FNHA) in British Columbia (with the exception of Orthodontic Services), please submit claims for reimbursement to:

BRITISH COLUMBIA FIRST NATIONS HEALTH AUTHORITY
Health Benefits
757 West Hastings Street
Suite 540
Vancouver, BC, V6C 3E6
Toll Free: 1-888-321-5003
Fax: 1-604-666-5815

For Residents of British Columbia who are not eligible for benefits under the FNHA
Please contact the Alberta Regional Office (see above) regarding your reimbursement claim. For dental and orthodontic reimbursements, send reimbursement requests to the Dental Predetermination Centre (see above).

NIHB CLIENT REIMBURSEMENT FORM

Before completing this form, please read the INSTRUCTIONS page, including the SUPPORTING DOCUMENTS section for what must be included with your reimbursement claim. For inquiries and/or mailing addresses, refer to the CONTACT INFORMATION.

✓ **Complete and sign the form.** ***Incomplete forms cannot be processed; forms that are not signed will be returned for signature.***

✓ **Include ALL the required documents (listed in the instructions) with your claim, and keep copies of your files.**

PART 1 – CLIENT INFORMATION (CLIENT RECEIVING THE SERVICE)

Surname:		First and Middle Names:	
Address:	Apt.:	Identification Number (i.e.: Status number OR N number):	
City:		Province/Territory:	
Telephone Number 1:	Extension:	Telephone Number 2 (optional):	Extension:
Postal Code:	Email Address (if email communication preferred):	Date of Birth: (YYYY/MM/DD)	

Are you covered for any of these expenses under any other health plan(s)/program(s)? ◯ **Yes** ◯ **No**
If yes, please attach a copy of a detailed statement or ***explanation of benefits form*** from all other plan(s)/program(s).

Reimbursement to: ◯ Client **Part 1** ◯ Other Payee **Part 2** | Inquiries to be sent to: ◯ Client **Part 1** ◯ Other Payee **Part 2**

PART 2 – PAYEE INFORMATION (IF REIMBURSEMENT IS CLAIMED BY SOMEONE OTHER THAN THE CLIENT RECEIVING THE SERVICE)

Last name:		First and Middle Names:	
Address:	Apt.:	Email Address (if email communication preferred):	
City:		Postal Code:	Province/Territory:
Telephone Number 1:	Extension:	Telephone Number 2 (optional):	Extension:
Relationship to client receiving service:			

PART 3 – BENEFITS / SERVICES RECEIVED (USE A DIFFERENT FORM FOR EACH BENEFIT TYPE)

BENEFIT TYPE (Select One): ◯ Pharmacy Benefits ◯ Medical Supplies & Equipment ◯ Vision and Eye Care ◯ Medical Transportation ◯ Dental/Orthodontic Benefits

List Benefits/Services Received:	**Cost**
TOTAL AMOUNT CLAIMED:	$ 0.00

PART 4 – SIGNATURE AND AUTHORIZATION (FORM MUST BE SIGNED IN ORDER TO BE PROCESSED)

I authorize the release of any records that are relevant to the processing and payment of the attached claims held by the service provider to Health Canada, its agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and that it does not contain a claim for any benefit or service previously paid for by Health Canada or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits.

Client (beneficiary) ◯ **Parent/Guardian** ◯

Print Name:	**Signature:**	**Date:** (YYYY/MM/DD)

PRIVACY NOTICE

The personal information you provide to Health Canada is governed in accordance with the Privacy Act. We only collect the information we need to administer benefits under the Non-Insured Health Benefits (NIHB) Program. Collection of information for this purpose is authorized under the *Department of Health Act*. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For more information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to and correction of your personal information. For more information about these rights, or about our privacy practices, please contact the Health Canada/Public Health Agency of Canada's Access to Information and Privacy (ATIP) Coordinator at 613-954-9165 or atip-aiprp@hc-sc.gc.ca. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

For inquiries and/or mailing address, please refer to the CONTACT INFORMATION page.

Ontario Ministry of Health and Long-Term Care

Application for Northern Health Travel Grant

The Northern Health Travel Grant (NHTG) Program helps defray travel related expenses of eligible Northern Ontario residents seeking medical specialist services or procedures at a designated health facility (e.g. CAT scan). Ministry travel grants are based on the distance to the closest medical specialist or designated health care facility able to provide the required health care services without a delay that would compromise the patient's health.

Please consider Telemedicine instead of travel: Ontario Telemedicine Network (OTN) supports almost every clinical specialty and may be an alternative to having patients travel. The OTN referral form is available at www.otn.ca/refer

***Please note*:**

- Patient must complete and submit a new, separate application for ***each*** round trip.
  Submit your application to: Ministry of Health and Long-Term Care
  199 Larch Street, Suite 801, Sudbury ON P3E 5R1
- Your NHTG application must be received by the Ministry of Health and Long-Term Care (MOHLTC) within twelve (12) months from the date of service.
- Requests for re-consideration/re-assessment of applications must be received within twelve (12) months from the date of payment, grant denial or date claim is returned to a client.
- Original tickets/stubs/receipts must be provided for travel by air, bus or rail for patient and/or companion; however, travel itineraries are acceptable if they show a fare was paid or accumulated airline travel credits were used. Do ***not*** submit receipts for gas or meals since these are not required and will not be returned.
- If several patients/their companions travel together in the same car, only one travel grant will be paid per round trip.
- 100 kms will be deducted from the total distance of the trip when calculating the amount of the travel grant.

Eligibility Criteria for a Patient Travel Grant – Patient ***must*** satisfy all of the following:

☐ 1. Must be a resident of Northern Ontario in the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury, Thunder Bay or Timiskaming ***and*** be an OHIP insured person on the date the service is provided.

☐ 2. Must be referred within Ontario or to Manitoba for specialist health care or designated health facility procedures that are insured services under the *Health Insurance Act*.

☐ 3. Must have travelled at least 100 kms (one way road distance) to obtain the required service from their area of residence to the location of the nearest medical specialist/designated health care facility referred to in Ontario or Manitoba.

☐ 4. Must be referred, before the travel takes place, by a northern physician, dentist, optometrist, chiropractor, midwife or nurse practitioner and ensure Section 2 of the application is completed.
Note: No additional referral is required within a 12 month period from initial referral/service date for travel to the same specialist/facility.

☐ 5. Must be referred to a ***medical specialist*** who is certified by The Royal College of Physicians and Surgeons of Canada (RCPSC), or a ***Winnipeg (Manitoba) physician*** enrolled on the ***Manitoba Health Specialist Register*** and permitted to bill as a specialist. **OR** must be referred to a physician who holds a specialist certificate of registration issued by the College of Physicians and Surgeons of Ontario (CPSO) in a recognized medical or surgical specialty other than family or general practice, or a health facility designated by the MOHLTC.
To verify a specialist's RCPSC certification using the internet, go to www.royalcollege.ca and follow these steps:
i. Specify language (English or French) below "Directory of Fellows". Click: "Confirm Status". Read and accept Disclaimer.
ii. Enter doctor's last name and city. Click: "Search" and check specialty/subspecialty.
Contact the NHTG Program to find out if a particular health care facility has been designated by the ministry.

☐ 6. Must confirm that travel costs are not covered by another program/organization such as WSIB, NIHB (Non-Insured Health Benefit Program for eligible First Nations and Inuit people) or private insurance (e.g. third party liability). Contact the NHTG Program for additional details.

For Assistive Devices Program (ADP) applications where patient is referred for fitting, adjustments or repairs for ADP approved orthotics and prosthetics, both the following criteria must be met:

1) vendor has an ADP authorizer registration number; ***AND*** 2) travel is for one of the following devices:
– breast prostheses – orthotics – prosthetics – conventional orthoses
– maxillofacial introral prostheses – ocular prostheses – burnscar pressure devices

Third Party Advance Funding – If any travel costs, including travel grant and/or accommodation allowance, have been covered in advance by an approved Third Party Agency, payment for which a patient is eligible will be made to that Third Party Agency. Contact the NHTG Program for additional details.

Eligibility Criteria for a Companion Travel Grant – Companion grant ***may*** be paid when all of the following are met:

1. Patient meets above travel grant eligibility criteria.
2. Patient is under 16 years of age on date of service or in the referring provider's professional judgement, patient is unable to travel without a companion. The referring provider must indicate this in Section 2 ***prior to the patient's travelling.***
3. Companion must be 16 years of age or older.
4. Companion must travel with the patient and pay a fare if travel is by air, rail or bus.

Eligibility for Accommodation Allowance – A patient ***must meet all of the following criteria*** in order to be eligible for the $100/round trip accommodation allowance:

1. The patient meets the travel grant eligibility criteria set out above: #1, 2, 4, 5 and 6.
2. The patient has travelled at least 200 kms (one way road distance) to obtain the required OHIP insured service from their area of residence to the location of the nearest medical specialist/designated health care facility referred to in Ontario or Manitoba.
3. The patient has submitted original accommodation receipts for services rendered on or after December 1, 2012.

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Avoid Delays – Incomplete applications will be returned.

To assist you in completing your application, please provide the required information for all applicable sections using the following checklist as a guide. Please type or print clearly on all sections of the application. Ensure your most current name and address information have been provided to the MOHLTC. If your address information provided on this application does not match your health number records, this form will be used to update your records. ***Correctly completed applications will avoid delays in the assessment of your application and in your grant payment.***

Section 1: **Patient** completes this section in full:

- ☐ Last Name, First Name and Health Number
- ☐ Date of Birth, Home Telephone Number, Work Telephone Number and Sex
- ☐ Home Address and Mailing Address (if different than Home Address)
- ☐ Confirm if all/part of travel cost is covered by another program/organization
- ☐ Type of Transportation
- ☐ Provide Original Receipts/Stubs for travel by commercial carrier
- ☐ Patient's Consent and Signature
- ☐ Effective December 1, 2012, if applying for the accommodation allowance, provide Original Accommodation Receipts for each treatment trip (e.g. official hotel/lodging receipts)

If the patient is a child under 16 years of age, the child's parent/guardian with custody may complete and sign the form on behalf of the child. If the patient is 16 or older but incapable of consenting on his/her own behalf, a Substitute Decision Maker (SDM) may complete and sign the form on the patient's behalf.

SDM's include patient's:

- Guardian who has authority to make a decision on behalf of patient;
- Attorney for Personal Care who has authority to make a decision on behalf of patient;
- Representative appointed by Consent and Capacity Board with authority to give consent;
- Spouse/Partner;
- Child/Parent or children's aid society or other person legally entitled to give/refuse consent;
- Parent with only right of access;
- Brother/sister;
- Other relative.

For more specific information on SDMs, please contact NHTG program directly (see General Contact Information below).

Section 2: **Northern Referring Provider** completes and certifies:

- ☐ Last Name and Initial(s)
- ☐ Provider Number and Billing Specialty
- ☐ Name of Specialist/Facility referred to and location
- ☐ An indication if referral was made/not made to the nearest specialist from the patient's area of residence
- ☐ Signature
- ☐ Signature for Companion Grant Request (*if applicable*)

Section 3: **Specialist/Health Facility Service Provider** completes and certifies:

- ☐ Last Name and Initial(s)
- ☐ Professional Designation (e.g. R.N., Technician)
- ☐ Provider Number and Billing Specialty (*if applicable*)
- ☐ Name of Hospital/Facility and City/Town the service was provided in
- ☐ Type of Service (*e.g. procedure, follow up visit, other reason*)
- ☐ Date of Service
- ☐ Signature

Section 4: If patient received advance funding, **Third Party Agency** (*e.g. Canadian Cancer Society, Kidney Foundation*) provides:

- ☐ Agency/Society's Full Name
- ☐ Patient's Signature
- ☐ Code Number
- ☐ Municipality Location of the Society or Agency

Section 5: If applying for a companion grant, **Companion** completes this section in full:

- ☐ Last Name and First Name
- ☐ Mailing Address
- ☐ Type of Transportation
- ☐ Signature (*verifies companion is 16 years old or older*)
- ☐ Receipts/ticket stubs for travel by commercial carrier

If travel is round trip by car, ***one half*** of the grant may be paid to the patient and the ***other half*** paid to the companion.

General Contact Information:

- Office hours are 8:30 a.m. to 5:00 p.m., Monday to Friday except holidays.
- For more information, call 705 675–4010 or 1 800 461–4006.
- Or go to www.health.gov.on.ca/en/public/publications/ohip/northern.aspx
- To obtain services in French, please call the toll free number 1 800 461–1149

***For current processing times**, go to our website:* http://www.health.gov.on.ca/en/public/publications/ohip/northern.aspx

Notice

The ministry cannot process your application unless you (and your companion, if applicable) provide the personal information required in sections 1 and 5 of the application. The ministry needs this information for the proper administration of the NHTG Program and will use and may disclose it for the purpose of determining your eligibility and processing your application. If you (and your companion, if applicable) do not consent to the ministry's collection, use and/or disclosure of this information, the ministry cannot process your application. For further information please contact the Manager, NHTG Program (see address information on previous page) or call 705 675-4010 or 1 800 461-4006.

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Ontario Ministry of Health and Long-Term Care

Northern Health Travel Grant Application

Print clearly in block letters. Ensure BOTH sides of this application are completed.

For Ministry Use Only – Do not write here

Section 1 – Patient Information (Refer to Instruction Sheet for more information)

Last Name | First Name | Health Number

Fee Code K036

Date of Birth (year / month / day) | Home Telephone Number ( ) | Work Telephone Number ( ) | Sex ☐ M ☐ F

Home Address (Street n°. and name) lot/conc/twp.

City/Town | O N | Postal Code

Mailing Address (if different from above, Box n°., R.R. n°., site)

O N | Postal Code

Type of Transportation ▶

Automobile *(receipts not required)*: ☐ One Way ☐ Round Trip

Commercial Carrier ***(Original tickets/stubs required)***: ☐ Air ☐ Rail ☐ Bus

Ambulance: ☐ One Way ☐ Round Trip

Response Preferred in: ☐ English ☐ French

Are this patient's travel costs eligible for reimbursement from another program/organization?

☐ No ☐ Yes, WSIB ☐ Yes, Private Insurance (e.g. third party liability) ☐ Yes, NIHB – Non-insured Health Benefit Program for eligible First Nations and Inuit people

By completing and signing this application, I consent to the MOHLTC's collection, use and disclosure of the personal health information I have provided on this form for the purpose of processing my application under the NHTG Program including determining my eligibility, auditing compliance and payments made under the program and monitoring, preventing and recovering any unauthorized receipt of any grant paid under the program. I understand that the MOHLTC may use and disclose this information in accordance with the *Personal Health Information Protection Act*, 2004, as set out in the Ministry's Statement of Information Practices, which may be accessed at www.health.gov.on.ca

I hereby certify that I am the:

☐ Patient ☐ Parent of a patient who is under 16 years of age ☐ SDM of the patient *(see instructions)*

Signature

X

Section 2 – Northern Referring Provider Information

Referring Provider's Last Name | Initials | Provider Number | Specialty

Specialist/Facility Referred to | Referring Provider's Telephone Number ( )

Municipality Referred to | Did you see the patient in Northern Ontario? ☐ Yes ☐ No | Referring Provider's Fax Number ( )

Is this referral to the specialist or facility nearest to the patient's area of residence that is capable of providing the required service?

☐ Yes ☐ No – please explain

I certify that based on my professional judgement, the patient is ***unable to travel without a companion.***

Referring Provider's Signature

X

I certify that the information provided in this section is correct.

Referring Provider's Signature

X

Section 3 – Specialist / Health Facility Service Provider Information

Last Name of Specialist / Service Provider | Initials | Professional Designation *(if applicable)* | Provider Number | Specialty

Name of Hospital/Facility Service Provided in *(if applicable)* | City/Town Service Provided in

Is this service for a

☐ Consultation ☐ Procedure ☐ Surgery ☐ Follow Up Visit ☐ Other

Date of Service (year / month / day)

Is this medical service for an OHIP insured service? ☐ Yes ☐ No

Is this service WSIB related? ☐ Yes ☐ No

Is this medical service for an ADP approved device? ☐ No ☐ Yes *(provide ADP Vendor N°)*

Is this medical service part of the Cleft Lip and Palate Program? ☐ No ☐ Yes *(provide Program N°)*

I certify that the information provided in this section is correct.

Specialist / Health Facility Service Provider's Signature

X

Telephone No. | **Fax No.**

Turn over to next page ▶

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Ontario Ministry of Health and Long-Term Care

Northern Health Travel Grant Application

Please print clearly in block letters.

For Ministry Use Only – Do not write here

Patient Information (*Required on both sides of the form*)

Last Name	First Name	Health Number

Section 4 – Advance Funding by Third Party Agency / Society (*if applicable*)

Name of Society or Agency			Code Number
Mailing Address			
Municipality	Postal Code	Telephone Number	Extension
O N		( )	

I hereby direct the ministry's NHTG Program to pay my travel grant pertaining to this Northern Health Travel application to the society or agency named above.

Signature of Patient / Parent / SDM of the patient *(see instructions)*

X

Section 5 – Companion Information (*if applicable*)

Last Name	First Name

☐ Same as patient address

Mailing Address

City / Town		Postal Code
	O N	

Type of Transportation

Automobile *(receipts not required)*: ☐ One Way ☐ Round Trip

Commercial Carrier ***(Original tickets/stubs required)***: ☐ Air ☐ Rail ☐ Bus

Ambulance: ☐ One Way ☐ Round Trip

I hereby certify that I am 16 years of age or older and I accompanied the above-named patient.

The personal information you provide on this form is necessary for the proper administration of the ministry's NHTG Program. The MOHLTC collects and may use and disclose this information for the purposes described in Section 1 above. If you have any questions about this collection, please contact the Manager, NHTG Program at 199 Larch St., Sudbury ON P3E 5R1 or by phone at 705 675–4010 or 1 800 461–4006.

Companion's Signature	**Telephone No.**
X	

This form is also available at www.ontario.ca

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