NORTHWEST TERRITORIES
Health and Social Services Authority

MEDICAL TRAVEL EXPENSE CLAIM FORM

(All Medical Travel must be pre-approved by local health facility and/or Medical Travel)

(Internal use only)
Case/Claim #:_____ Org (Primary): 1841-__ Invoice Date:_____ Approval #:_____

Claim Payable To:	Email Address:
Full Mailing Address:	Phone #:
Patient Name:	Escort Name (if applicable):
Patient Full Mailing Address:	

Start Date	End Date	Description	Location		Quantity	Rate	Total ($)
		Patient Accommodation				**$50/night**	
		Escort Accommodation				**$50/night**	
		Patient Meals				**$18/day**	
		Escort Meals				**$18/day**	
Departure Date	**Return Date**		**Departure**	**Destination**			
		Self-drive One way ☐ / Return ☐				**$0.27/KM**	
		Patient airfare One way ☐ / Return ☐					
		Escort airfare One way ☐ / Return ☐					
		Local Taxis/shuttle					
		Copayment deduction (if applicable) $200 one-way, $400 round trip					
						Total Claimed	

- **PROOF OF ATTENDANCE AT APPOINTMENT(S) IS REQUIRED FOR CLAIM REIMBURSEMENT (Page 2).**
- Medical Travel will only reimburse the most economical and cost effective route for your medical travel trip.
- Original receipts with cost, departure and destination information must be attached for airfare, shuttle bus and taxis.
- No taxi fares are reimbursed from/to the International Airport in Edmonton to hotel (Shuttle Only) or to/from approved boarding homes.
- Taxis are only reimbursed to/from accommodation, appointments, airports (not Edmonton) and pharmacies up to a maximum of $25 per trip.
- Private vehicle mileage is only authorized and reimbursed between communities and must be substantiated with fuel receipts.
- Parking and mileage at the destination are NOT reimbursed.

I acknowledge and accept the current terms and conditions of the GNWT's Medical Travel Policy.

Client		Approver (NTHSSA)	
_____	MM/DD/YYYY	_____	MM/DD/YYYY
Signature		Signature	

Claims must be submitted within three (3) months of travel end date. Please be advised, claim may take 4 – 6 weeks to process.

Claim can be mailed to:
Your regional medical travel office
Or
NTHSSA – Medical Travel
Box 10, 548 Byrne Road
Yellowknife NT X1A 2N1
FAX: (867) 920-2172 EMAIL: ykmedicaltravel@gov.nt.ca

Date Received by Regional Office: _____
Date received by YK office: _____
Date reviewed/processed: _____
Completed by: _____

IF CLAIM FORM IS INCOMPLETE IT WILL BE RETURNED – BOTH PAGES ARE REQUIRED

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Proof of Attendance

Patient Name: ___________________Health Care #: ____________ Date of Birth:______________

This form certifies that the patient has attended the following appointment(s):

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Location:	Date:	Time:
Medical Practitioner (print)	Medical Practitioner (signature)	

Please use back of form for additional appointments or comments.