



MEDICAL TRAVEL EXPENSE CLAIM FORM

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

(Updated April 1, 2026)

(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 <input type="checkbox"/> / Return <input type="checkbox"/>				\$0.295KM		
		Patient airfare One way <input type="checkbox"/> / Return <input type="checkbox"/>						
		Escort airfare One way <input type="checkbox"/> / Return <input type="checkbox"/>						
		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 _____ <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px; text-align: center; color: gray;">MM/DD/YYYY</div> _____ Signature	Medical Travel Approver (NTHSSA) _____ <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"></div> _____ Signature
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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

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.