

MEDICAL TRAVEL EXPENSE CLAIM FORM

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

(Updated October 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 ☐ / Return ☐				\$0.35/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 _____ MM/DD/YYYY	Medical Travel Approver (NTHSSA) _____
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:	_____

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.