First Nations Health Authority
Health through wellness

HEALTH BENEFITS MEDICAL TRANSPORTATION REQUEST FORM

Toll Free Phone Number: 1-800-317-7878	Toll Free Fax Number: 1-888-299-9222	
Local Phone Number: 604-666-3331	Local Fax Number: 604-666-3200	
Mailing Address: #540-757 Hastings Street W.	CITY/PROVINCE: VANCOUVER, BC	POSTAL CODE: V6C 1A1

Part 1 – Client Information

Surname:		First and Middle Names:
Status Number: BC Health Care Card Number:		Date of Birth: / / YY/ MM/ DD):
Address:		Telephone Number#:
City:	Province/Territory:	Postal Code:

Part 2 – Escort Information

Escort Required	YES _____	NO ____	Status Number (if applicable)
Escort Name:			Date of Birth: : / / (YYYY/MM/DD)

Part 3 – Health Practitioner / Health Facility Information

Name:	Telephone Number:
Address:	City/ Province/Territory:
Specialty:	Appointment Date(s) and Time(s):

Part 4 – Travel Information / Mode of Transportation

Date of Departure:				Return Date:
Transported From:				Transported To:
Transportation Type:	☐ Plane	☐ Bus	☐ Boat	☐ Wheels for Wellness
	☐ Taxi	☐ Private Vehicle: _____x $0.23/KILOMETRE = $_____		

Part 5 – Accommodation

Accommodation Type:	☐ Commercial ☐ Private	
Accommodation Check – In Date:		Accommodation Check – Out Date:
Indicate if two (2) Beds Required: YES or NO		Wheelchair accessible Room Required: YES or NO
Total Amount of Meals Requested:		

Part 6 – Authorization and Signature

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to First Nations Health Authority, it's 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 do not contain a claim for any benefit or service previously paid for by First Nation Health Authority; Health Canada; or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits.

Client, Parent, Guardian or Person having a legally recognized authority **Date:** / / (YYYY/MM/DD)

Print Name: **Signature:**

Please complete this form and attach a copy of the referral letter (if applicable), including the specialist's information, confirmation of appointment, Physician Escort Form (if applicable).

Note: Original Receipts for Hospital Parking, Tolls, Ferry, Air, Bus, Taxi, and Hotel MUST be mailed to our office indicating to whom it should be payable to with the referral and confirmation of appointment.