First Nations Health Authority
Health through wellness

HEALTH BENEFITS MEDICAL TRANSPORTATION REQUEST FORM

Toll Free Phone Number: 1-855-550-5454	Toll Free Fax Number: 1-888-299-9222	Email: Transportation@fnha.ca
Mailing Address: 701 - 1166 Alberni Street	CITY/PROVINCE: VANCOUVER, BC	POSTAL CODE: V6E 3Z3

Part 1 – Client Information

Surname:		First and Middle Names:	
Status Number:	BC Health Care Card Number:	Date of Birth: YYYY / MM / DD	
Street Address:		Telephone Number#:	
Mailing Address (If different than Street Address):		Email Address:	
City:	Province/Territory:	Postal Code:	☐ On Reserve ☐ Off Reserve

Part 2 – Escort Information / Home address:

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

Part 3 – Health Practitioner / Health Facility Information / Appointment 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	☐ Taxi
	☐	☐ Private Vehicle		

Part 5 – Accommodation

Accommodation Type:	☐ Hotel/Motel	Accommodation Check – In Date:	Accommodation Check – Out Date:
	☐ Private (Family / Friend)		
	☐ Other		
Indicate if two (2) Beds Required: ☐ YES or ☐ NO	Wheelchair accessible Room Required: ☐ YES or ☐ NO	Meals Reimbursed: Y / N (if no, we will do our best to book at hotel that authorizes meals)	

same- day meal rates are eligible for travels over 6 hours

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, 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 do not contain a claim for any benefit or service previously paid for by First Nation Health Authority; 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.