# Ditidaht Community Services

P.O. Box 340 Port Alberni, BC V9Y 7M8 PH: 250-745-3331 FAX: 250-745-3741

Ditidaht
FIRST NATION

## HEALTH BENEFIT MEDICAL TRANSPORTATION REQUEST FORM

**Part 1 - Client Information**

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

**Part 2 - Escort Information**

| | | | | |
|---|---|---|---|---|
| Escort Required: | Yes_____ | No_____ | | Status # (if applicable): |
| Escorts Name: | | | | Date of Birth: YY/ MM/ DD |

**Part 3 - Health Practitioner/ Health Facility Information**

| | |
|---|---|
| Name: | Telephone #: |
| Address: | City/Province/Territory: |
| Specialty: | Appointment Dates and Times: |

**Part 4 - Travel Information/Mode of Transportation**

| | | |
|---|---|---|
| Date of Departure: | | Return Date: |
| Transported from: | | Transported to: |
| Transportation Type | Plane☐ Bus☐ Boat☐ Wheels of Wellness☐ Taxi☐ | |
| | Private Vehicle ☐ _____X $0.23 / KILOMETERS = $_____ | |

**Part 5 - Accomodation**

| | | | |
|---|---|---|---|
| Accomodation Type | Commercial ☐ | | Private ☐ |
| Accomodation Check in Date: | | Accomodation Check out Date: | |
| Indicate if two (2) beds required: | | Yes____ | No_____ |
| Wheelchair accessible room required: | | Yes____ | 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 Nation Health Authority, its agents or contractors, or any appropriate Health Professional Licencing or Regulatory Body for the purpose of administration 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 Heath Authority; Health Canda; or by any other plan(s).

Client, Patient, Guardian or Person having a legally recognized authority DATE:

| 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.