

PATIENT must return completed form to:

Drop off
4th floor
Financial Plaza Building
204 Lambert Street
Whitehorse, Yukon

Mail
Medical Travel, Health Services, H-2
Box 2703
Whitehorse, Yukon
Y1A 2C6

Phone (867) 667-5203 or toll free, 1-800-661-0408, local 5203
Fax (867) 393-6486

The following persons are not eligible for medical travel benefits through this program.

- Employees who are injured or taken ill in the course of their employment are covered by the Yukon Workers' Compensation Health and Safety Board.
- Status persons, members of the Armed Forces, Canada Post, the RCMP and Federal Government employees, their spouses or dependents are covered under other Federal or Yukon Acts.

Important: Failure to obtain referral and verification signatures in Part 2 of this form will result in non-payment.

Please print clearly or type.

PART 1: PATIENT INFORMATION

Date of Birth (year/month/day) _____

Name _____ Yukon Health Care Number 002 _____
Last name First name Initial

Home address _____ Telephone (h) _____ (w) _____

PART 2: MEDICAL INFORMATION (The following information is required)

Diagnosis _____

Reason for travel _____

Escort Name _____ Medical Reason _____

Appointment dates (y/m/d)	Time	Dr. Name	Service	VERIFICATION SIGNATURE (I hereby verify that the patient was present for the following referred medical services.)
				Date _____
				Date _____
				Date _____

Referred by _____
SIGNATURE OF NURSE PRACTITIONER OR DOCTOR DR. # DATE (Y/M/D)

PART 3: TRAVEL INFORMATION - Failure to complete this section may delay your payment or result in non-payment.

Date of Travel (y/m/d) _____ Travelled from _____ to _____ Return Date _____

Travel by private vehicle bus (submit ticket stub) air (submit ticket stub) Medivac - air one-way return

Cheque should be made payable to (Please ensure that the following information is accurate or payment may be delayed.)

Name _____ Address _____

SIGNATURE OF PATIENT OR GUARDIAN DATE (Y/M/D)

PART 4: TRAVEL SUBSIDY

The purpose of the subsidy is to assist patients with expenses while they are receiving outpatient medical care. Payment will be made to the patient. No receipts are required. The subsidy is \$75 per day, starting on the second day of medical travel status to a maximum of 90 days.

OFFICE USE ONLY						
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Subsidy - patient _____ days @ \$75/day = _____ .00

PART 5: OFFICE USE ONLY approved not approved

Date (y/m/d) _____

MEDICAL OFFICER OF HEALTH FOR MEDICAL TRAVEL