NUNATSIAVUT
kavamanga Government

HEALTH AND SOCIAL DEVELOPMENT

PROTECTED HIGH
CONTAINS PERSONAL OR SENSITIVE INFORMATION

NON-INSURED HEALTH BENEFITS

CLAIM FOR MEDICAL TRANSPORTATION REIMBURSEMENT

It is important to submit **ALL** required documents and complete **ALL** sections, date and sign the claim.
Please keep a copy of this form and all supporting documents for your records.

INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

- Did you submit your original receipt(s)? Credit card/Debit (Interac) slips are not acceptable forms of proof of payment.
- Did you include confirmation of medical appointment attendance?
- All sections of this claim form must be completed, signed and dated.

Trips require **Prior Approval** by calling **NIHB toll-free 1-866-606-9750**, Medical Transportation Division, Extension 230, 226, 247.
ALL emails should be sent to nihb@nunatsiavut.com. All faxes should be sent to 709-896-9761.

Section 1 – Beneficiary Information (Beneficiary receiving the service)

Beneficiary's Full Name:		
Date of Birth:	**N Number:**	**Beneficiary's Phone Number:**
Beneficiary's Mailing Address:		
Town:	**Province:**	**Postal Code:**
Escort's Name (if applicable):		

Section 2 – Payment Information

All parts of this section must be completed in order for reimbursement to be paid.
Please provide the name and address of the person/facility to whom payment should be made. The payee must be over the provincial legal age of nineteen (19).

IF PAYEE INFORMATION IS THE SAME AS BENEFICIARY INFORMATION CHECK HERE ☐	**ARE YOU SET UP FOR DIRECT DEPOSIT WITH DHSD?** ◯ **Yes** ◯ **No**

If you need to set up direct deposit with NIHB please email financedhsd@nunatsiavut.com and request a direct deposit form.

Reimbursement cheque should be made payable to:		
Mailing Address:		**Town:**
Province:	**Postal Code:**	**Phone Number:**

Section 3 – Appointment Information

All information must be provided in order to be considered for reimbursement including proof of attendance from the health facility.

Appointment Date:	**Appointment Time In:**	**Appointment Time Out:**
Health Professional's Name:		**Health Facility's Phone Number:**
Health Facility Name and Address:		

Section 4 – Claim Information

Is the health service identified in "Section 3 – Appointment Information" being covered by your provincial health plan or by the Non-Insured Health Benefits Program? ◯ **Yes** ◯ **No**

Are you covered for any of these expenses under any other health plan(s)/program(s)? ◯ **Yes** ◯ **No**

If **YES**, please attach a copy of a detailed statement or explanation of benefits form from all other plan(s)/program(s).

PLEASE INDICATE WHAT MEDICAL TRANSPORTATION BENEFITS ARE BEING CLAIMED, IF THIS INFORMATION IS NOT PROVIDED OR IS INCOMPLETE, THE CLAIM AND ANY ATTACHED RECEIPTS WILL BE RETURNED TO THE CLAIMANT UNPROCESSED.

Travel Distance: *# of Kilometers (Return Trip)* **km**	**Rate Of: $ 0.28/km**	$ 0.00

Departing From (Community Name):	**Arriving To (Community Name):**

ACCOMMODATIONS *(when trips over 600 km return). If claiming private accommodations the claimant can claim $50 per night without meals, or can claim $100 per night with meals.*

Name of Accommodation Facility:	**Accommodation Cost: $**

MEALS *Receipts are not required as we pay per diem. Trip duration must be a minimum of three (3) hours or more in order to claim meals, unless appointment times are near meal time. Meals will **not** be reimbursed when Private Accommodation(s) has been paid out to another Claimant.* **Rate Increase Effective April 1, 2026**

Regular (ages 4 to adult) Meal Cost: * A maximum daily total of $76.00

Number of Breakfasts ($19.00):	**Number of Lunches ($19.00):**	**Number of Dinner/Suppers ($38.00):**

Infant/toddler (ages 0-3, inclusive) Meal Cost: * A maximum daily total of $38.00

Number of Breakfasts ($9.50):	**Number of Lunches ($9.50):**	**Number of Dinner/Suppers ($19.00):**

Total Meal Cost Being Claimed: $ 0.00

Please attach a separate sheet explaining your claim in greater detail or if additional space is required.

Section 5 – 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 NIHB – NG, its agents or contractors, or any other appropriate health professional licensing or regulatory body for the purpose of an administrative audit. I declare that the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by NIHB - NG or by any other plan(s)/program(s) that is noted in the statement or explanations of benefits.

Patient's Signature:	**Date:**

(This signature is mandatory. If the Beneficiary is under the age of 19, then the parent/legal guardian must sign)

Mail this completed form along with receipt(s) (if applicable) to:

Non-Insured Health Benefits (NIHB), Medical Transportation Division,
P.O. Box 496, Station C, Goose Bay, NL, A0P-1C0,

By **Fax**: 1-709-896-9761 or **Email**: nihb@nunatsiavut.com (*original ferry/hotel receipts must be mailed in, if applicable)*