MEDICAL TRAVEL SUBSIDY

☐ **In-territory** ☐ **Out-of-territory**

Patient must return completed form to Medical Travel.

Secure drop box
Deposit this form in the secure drop box at Erik Nielsen Whitehorse International Airport or Whitehorse General Hospital.

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

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

Email: medicaltravel@gov.yk.ca
Phone: 867-667-5203 or 867-667-5233 (can call collect)
Fax: 867-393-6486

The purpose of the subsidy is to assist patients with expenses while they are receiving outpatient medical care. Payments will be made to the patient and/or their escort. No receipts are required.

A parent is eligible for a subsidy while their child is admitted into a hospital.

Patients receiving long-term outpatient care can fax or email this form to us weekly. It will be processed as soon as it is received.

Patient information

Full name (first, middle initial, last)		Yukon Health Care Number 00___ ___ ___ ___ ___ ___ ___
Travel by: ☐ Air ☐ Road Travel from: _____ to: _____	Departure date YYYY/MM/DD	Return date YYYY/MM/DD

Confirmation of medical services

Medical service received	If in and out same day	If admitted overnight or multiday		Hospital or clinic	Verification signature (doctor, nurse, technician)
	Appointment date	Admission date	Discharge date		
Examples:					
Total hip replacement	YYYY/MM/DD	*2019/01/21*	*2019/01/28*	*Royal Columbian Hosp.*	*Signature*
MRI	*2019/01/30*	YYYY/MM/DD	YYYY/MM/DD	*Whse General Hosp.*	*Signature*
	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		
	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		
	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		
	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		
	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		

Make subsidy cheque payable to ☐ Patient ☐ Escort ☐ Separate cheques

Full name of patient	Phone
Address	
Full name of escort (if approved)	Phone
Address	

Signature

Is this a WCHSB-related injury? ☐ Yes ☐ No

Do you have insurance coverage from one of the following? ☐ Yes – check all that apply ☐ No

☐ RCMP ☐ Status First Nation ☐ Canada Post ☐ Federal government (e.g. Parks Canada/DFO)

I verify that the information contained on this form is true to the best of my knowledge.

_____ YYYY/MM/DD _____

Signature of patient or guardian — Date

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				

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				

Patient subsidy

____ days @ $_____ / day = _____.00

____ days @ $_____ / day = _____.00

Escort subsidy

____ days @ $_____ / day = _____.00

____ days @ $_____ / day = _____.00

Information contained in this form is collected, used and disclosed in accordance with Yukon's *Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can viewed at www.hss.gov.yk.ca/healthprivacy.php or by contacting the department's Privacy Officer at healthprivacy@gov.yk.ca