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|  Designated Organization Name: |  ☐ Contribution |  ☐ Non-Contribution |
|  Contact Name: |  Date of Request:  |
|  Phone #: |  Fax #: |
|  **Client Information:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  Status #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PHN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Reason for Exception (please check one and provide description)**❐ ESCORT ❐ ESCORT CLIENT IN HOSPITAL ❐ NNADAP ❐ NOT CLOSEST PROVIDER ❐ OVER 5 DAYS ❐ OVER 30 DAYS ❐ EXTENSION ❐ DENTAL ❐ OTHER **Please provide justification for exception, including any supporting documentation.**Are any of these expenses covered under any other public or private health care plan: Yes No |
| Referred By: | Referred To: |
| Specializes In: | Reason for Referral: |
| Appointment Date: | Appointment Time: |
| Travel From: | Travel To: |
| Date of Departure: | Date of Return: |
| Escort’s Name: | Relationship: Age: |
| Accommodation: | Check- In: Check-Out: |
| Travel By: Please circle all applicable Car Air Bus Ferry Taxi Medical Van Mileage (if applicable) : \_\_\_\_\_\_\_\_\_\_ one way | **Additional Comments:**  |

**Please fax request along with supporting documentation (e.g. Doctor’s referral, Confirmation of Specialist appointment, Physician Escort Request Form, and any additional information) to FNHA, Health Benefits, Exceptions at: 1-604-666-0292. Incomplete forms will be returned. Please submit FIVE (5) days before travel. A fax transmittal will be sent with decision.**