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