

National Travel Assistance Claim Form



- This form must be completed in full by the Client registered for National Travel Assistance or their representative. Please sign on reverse, incomplete forms will be returned.
- Post the completed form to: National Travel Assistance, PO Box 1026, Wellington.
- For help with the form phone National Travel Assistance on **0800 281 222** (press 2).

Client ID

1. CLIENT DETAILS

First Name(s)				Last Name					
NHI Number		Date of Birth		Gender		Community Services Card Number		Expiry Date	
		D D M M Y Y Y Y		<input type="radio"/> Male <input type="radio"/> Female		0 0 0 0 0		D D M M Y Y Y Y	

2. PAYMENT DETAILS – Name of bank account where your claim will be paid.

Account Name				Bank					
Branch				Bank Account Number					
		Bank		Branch		Account Number		Suffix	

3. ONLY COMPLETE IF YOUR ADDRESS HAS CHANGED SINCE YOUR REGISTRATION OR LAST CLAIM?

Date of address change

Unit/Flat No:		Street No:		Rural ID:		Street Name		D D M M Y Y Y Y	
Suburb				City/Town					
Alternative Postal Address (ie. PO Box)						Postcode			
Contact Phone Number				E-mail Address					

IMPORTANT INFORMATION AND CHECKLIST FOR CLAIMING

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> You must register and be eligible before you can claim travel assistance. <input type="radio"/> Please take this claim form to your appointments to be signed and stamped as attended by treating department/hospital. <input type="radio"/> Please attach itemised receipts for public transport and accommodation – NOTE: ATM, EFTPOS and photocopied receipts are NOT accepted. | <ul style="list-style-type: none"> <input type="radio"/> If this is your first claim, or your bank account details have changed, please attach a printed deposit slip or the top of your bank statement or an account verification from your bank. <input type="radio"/> The Ministry of Health must receive your claim form within 90 days of the date of treatment to qualify for payment. |
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Please turn overleaf to complete claim details declaration

4. EXPENSE DETAILS

Date	Tick for one way trip by private vehicle	Public and Specialised Transport costs	Accommodation costs	Tick if Support person costs	Attending facility/hospital treating department	Signature of hospital confirmation and stamp (proof of attendance)
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
D D M M Y Y Y Y	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>		
Totals		\$	\$			

Mileage is calculated at registration from the client's residential address to the attending facility/hospital treating department via the shortest practical route.

5. DECLARATION

I understand that:

- this form will be sent to the Ministry of Health where my claim will be processed on behalf of my DHB and that my DHB and the Ministry of Health may use this information to pay my claim and monitor access to health and disability services in a manner consistent with the Privacy Act 1993
- the information I provide will be held securely by the Ministry of Health and my DHB and will be kept confidential except when required to be disclosed by law. I have the right to access this information by enquiring to the Ministry of Health and I may also request that it be corrected
- the Ministry of Health can decline reimbursing the expenses of any person who does not meet Ministry of Health eligibility criteria
- the Ministry of Health is not obliged to enter into any correspondence as a result of any decision made in relation to reimbursement under the National Travel Assistance Scheme
- if the Ministry of Health makes an overpayment to me, I may be obliged to repay the amount of the overpayment and that the Ministry of Health will contact me to discuss repayment options.

I declare that the above information is true and correct

Signature

Date / /

Signature of claimant or their representative. A parent or guardian may sign on behalf of a child.