National Travel Assistance Registration Form

MINISTRY OF HEALTH
MANATŪ HAUORA

- **This form must be completed in full by the client registering 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 6140.**
- For help with the form phone National Travel Assistance on **0800 281 222** (press 2).

Client ID

1. CLIENT DETAILS

New Registration ☐ Amended Registration ☐

First Name(s)

Last Name

NHI Number

Date of Birth D D M M Y Y Y Y

Gender ◯ Male ◯ Female

Community Services Card Number 0 0 0 0 0

Expiry Date D D M M Y Y Y Y

Residential address

Unit/Flat No: Street No: Rural ID: Street Name

Suburb City/Town

Alternative Postal Address (ie. PO Box) Postcode

Contact Phone Number Cell Phone E-mail Address

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

2. REFERRED TO FOR TREATMENT to be completed by the referring health or disability specialist

Treating Department (in full) eg. orthopaedic, oncology, cardiology, Van Asch etc.

Name of Hospital(s) Service Provider(s)

City/Town Treatment commences on D D M M Y Y Y Y

How many visits is your client likely to need during the course of their treatment?

◯ Less than 6 visits in the next 6 months ◯ 6 or more visits in the next 6 months
◯ 22 or more visits in the next 2 months

Is this registration for an organ donation? ◯ Yes ◯ No

ACC – Is your client claiming travel to attend treatment for an injury that is a result of an accident?

◯ Yes ◯ No When did this occur? D D M M Y Y Y Y ACC 45 claim number

ACCOMMODATION – If funding is required for accommodation, please advise reason.

◯ Travels over 100km one way ◯ Client's medical condition ◯ Client long stay near hospital

Funding for accommodation when travelling under 100km one way requires an approval letter from the specialist.
Funding for accommodation **greater than 16 consecutive nights** requires an approval letter from the specialist.

SUPPORT PERSON

Name of attending support person

If funding is required for a support person, please advise the reason

- ◯ Parent of a child client
- ◯ Clinical decision maker
- ◯ Learning technical skills – Ongoing
- ◯ Client well being
- ◯ Accessing Services
- ◯ Emotional/Physical Support
- ◯ Assistance with clinical decision
- ◯ Escorting clinical care

Funding for a second support person requires an approval letter from the specialist.

SPECIALISED TRANSPORT – If funding is required for specialised transport please advise the method

◯ Air Travel ◯ Taxi/Shuttle ◯ Mobility Taxi ◯ Ferry ◯ Other (please specify)

Reason for specialised transport

◯ Client or support person's medical condition or disability ◯ Due to distance travelled ◯ Other (please specify)

3. REFERRING SPECIALIST SIGN-OFF

Specialist Name

Medical Council Number (MCNZ)

Referring Hospital

Contact Phone Number

Are you signing on behalf of the Specialist?

◯ Yes – Your name

I, the referring Specialist/designated signatory, certify that the above information is true and correct.

HOSPITAL STAMP

SIGN HERE

Date: D D M M Y Y Y Y

◯ Please tick if it is not reasonably practicable for the client to complete Section 1 of this registration form or sign the declaration.

(Note: Specialist may only sign in their capacity as a publicly funded Health or Disability Specialist)

4. DECLARATION

I, the client registering for National Travel Assistance, understand that:

- this form will be sent to the Ministry of Health where my registration 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 National Travel Assistance Scheme is funded according to the National Travel Assistance Policy Document effective 1 January 2006, published and amended from time to time by the Ministry of Health, and that the Ministry of Health may decline an entitlement to receive that assistance
- this registration is valid only for this course of treatment
- 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.