CMAW Benefit Plan

1000 – 4445 Lougheed Hwy, Burnaby, BC V5C 0E4
Toll-Free: 1.844.366.2629 Fax: 604.433.8894
cmaw@bgbenefitsadmin.com

TRAVEL ASSISTANCE – APPLICATION FOR REIMBURSEMENT

Member Name: _____ Member Number:_____

Address: _____ Phone ( )_____

City: _____ Postal Code: _____

Nature of sickness or injury: _____ **Work related? Y __ N ___**

Date of Illness or injury: _____ **MVA? Y ___N ___**

Expenses recovered from other source Y ___ N ___ **Source**: _____

If yes, copy of Explanation of Benefits Statement itemizing amounts reimbursed is required.

Means of travel to specialized services:

___Air Date _____

___Bus Date _____

___ Ferry Date _____

___ Car Date _____

Escort fare paid only if referring physician specifies an escort is required or if the patient is a child.
Please note we use Google Maps to determine mileage.

_____ _____

Signature of member **Date signed**

Please enclose with this claim form:

- ❑ Medical Certificate completed and signed by both referring and treating physicians
- ❑ Original paid receipts for fares and accommodation, if applicable
- ❑ Explanation of Benefits statement confirming amount paid by any other source, if applicable

Maximum 8 claims reached Y ___ N___

Adjudicator_____

Date processed _____

RULES AND GUIDELINES

The Travel Assistance Benefit is a reimbursement program which provides financial aid to members and their dependents who require medical or dental treatment from a qualified physician, surgeon, or oral surgeon not available in the member's community.

- The patient must be covered under the CMAW Benefit Plan of BC as a member or eligible dependent at the time of the treatment.
- A Travel Assistance claim may be made for a logistically and/or medically required period **to a maximum of eight days**. In assessing the number of eligible days, we look at:
  a) the distance traveled
  b) the means of travel,
  c) the dates of treatment
  d) whether or not the treating physician reports that the patient needs recovery time before traveling home.
- The Travel Assistance Benefit only reimburses for travel within the member's province of residence. Exceptions may be made where members in the Kootenays and Dawson Creek area are referred to Calgary and Edmonton for treatment. All other travel outside the province of residence must be authorized by the Trustees. If travel is by air, we will reimburse based on the lowest available air fare.
- $25.00 will be deducted from the travel costs and the balance will be reimbursed at 85%.
- A per diem allowance rate of $90.00 will be paid per day of travel for meals and miscellaneous expenses to a maximum of eight days. This per diem is for one or both travelers; there is no increase to the per diem if the patient is accompanied by an escort.
- Accommodation costs are reimbursed if receipts are submitted up to a maximum of $150.00 per day.
- **The Plan will provide Travel Assistance reimbursement to a maximum of eight trips per dependent per disability**.
- The Plan reserves the right to request further information or make any inquiries needed to properly adjudicate the claim.

EXCLUSIONS:

- procedures considered not medically necessary by the Medical Services Plan of BC, or
- any services provided by the Provincial Government or a Government Agency (including Workers' Compensation Board), or
- when a third party is liable (e.g. Insurance Corporation of British Columbia), or
- when coverage for Travel Assistance is already provided by an Extended Health Benefits plan.

Claims for the previous year must be received in the Plan office by June 30th in order to be eligible for reimbursement.

MEDICAL CERTIFICATE FOR TRAVEL ASSISTANCE CLAIMS

Patient's name

Address | City | Province | Postal Code

REFERRING PHYSICIAN'S STATEMENT

**Not required for psychiatric assessments of dependents.*

Physician's name

Office Address | City | Province | Postal Code

Nature of Illness or Injury

Reason for referral

Hospitalization required? **Y ❒ N ❒**
If yes, as outpatient? **Y ❒ N ❒**
Escort required? **Y ❒ N ❒**

Signature of Physician | **Date signed**

TREATING PHYSICIAN'S STATEMENT

Physician's name

Office Address | City | Province | Postal Code

Type of Treatment

Date/s of Treatment | Expected Date Patient Fit to Travel Home

Signature of Physician | **Date signed**

It is the member's / applicant's responsibility to have this form completed by both the referring and treating physicians and mailed together with the claim form and original receipts for eligible expenses to:

CMAW BENEFIT PLAN
1000 – 4445 Lougheed Hwy
Burnaby, BC V5C 0E4
Toll-Free: 1.844.366.2629 Fax: 604.433.8894