

NHS HIGHLAND

HIGHLANDS AND ISLANDS PATIENTS' TRAVEL EXPENSES CLAIM FORM

SECTION 1: TO BE COMPLETED BY WARD OR RECEPTION STAFF – PLEASE PRINT

PATIENT'S NAME: **CHI NUMBER:**

OR DATE OF BIRTH

ADDRESS:

.....

.....

POSTCODE **DAYTIME CONTACT NO:**

NAME & ADDRESS OF YOUR GP PRACTICE :

SECTION 2: TO BE COMPLETED BY (OR ON BEHALF OF) PATIENT

HOSPITAL ATTENDED:

WARD NUMBER/NAME: **HOSPITAL CONSULTANT:**

INPATIENTS: DATE OF ADMISSION:/...../..... TIME OF ADMISSION:

DATE OF DISCHARGE:/...../..... TIME OF DISCHARGE:

OUTPATIENTS AND DAYCASE PATIENTS: DATES AND TIMES OF APPOINTMENTS:

1. / / :

2. / / :

3. / / :

4. / / :

SECTION 3: TO BE COMPLETED BY HOSPITAL STAFF

I confirm that the patient named above attended this hospital on the dates stated: **HOSPITAL STAMP**

Signature:

Print Name :

Designation:

Date:/...../.....

SECTION 4: TO BE COMPLETED BY (OR ON BEHALF OF) PATIENT

| DATES: | DETAILS OF TRAVEL & NECESSARY OVERNIGHT ACCOMMODATION (Indicate journey type and whether Return or Single). | COST FOR PATIENT | COST FOR ESCORT |
|--------|---|---------------------|--------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| | TOTAL TRAVEL EXPENSES | | |

SECTION 5: TO BE COMPLETED BY GP, CONSULTANT OR SENIOR NURSING STAFF (FOR PATIENTS AGED 16YRS OR OVER)

I CERTIFY THAT I CONSIDER IT NECESSARY ON MEDICAL GROUNDS FOR THIS PATIENT TO BE ACCOMPANIED - **To HOSPITAL**
FROM HOSPITAL
TO AND FROM HOSPITAL

SIGNATURE DESIGNATION

AUTHORISED ESCORT'S NAME:

NOTE: ESCORTS WILL ONLY BE AUTHORISED IF NECESSARY ON MEDICAL GROUNDS. THE DECISION OF THE GP, CONSULTANT OR SENIOR NURSING STAFF IS FINAL

PLEASE STATE REASON FOR USING TAXI (IF CLAIMED FOR):

PLEASE STATE REASON FOR OVERNIGHT STAYS (IF CLAIMED FOR):

Only necessary travel expenses in excess of £10.00 for each return journey to hospital will be reimbursed unless the patient is in receipt of one of the following income based benefits : Income Support / Income-based Employment and Support Allowance / Income-based Job Seeker's Allowance / Pension Credit (Guarantee Credit) / NHS Tax Credit Exemption Certificate / HC2 Certificate / Universal Credit.

**I certify that I am in receipt of NI/Certificate No
Evidence of eligibility (eg. benefits letter) must be produced with each claim form submitted**

DECLARATION AND SIGNATURE BY (OR ON BEHALF OF) PATIENT:

I certify that I live or am permanently employed in the NHS Highland area and declare that the information I have given on this form is correct and complete and that I have not claimed elsewhere for the expenses detailed on this form. I understand that if I knowingly provide false information this may result in legal action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by NHS Highland and Counter Fraud Services for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Patient's Signature: _____ **Date:** _____

CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF RETURNING FROM HOSPITAL

SECTION 6: FOR USE BY TRAVEL SCHEME ADMINISTRATION ONLY

I have checked the details of this claim as listed above and hereby authorise payment of £ _____

Signature: _____ Designation: _____ Date: _____

FINANCE CODES :

NOTES:

1. Patients who live in Caithness, Sutherland, Ross & Cromarty, Inverness, Argyll, Arran, Bute, or Nairn, who have to travel more than 30 miles or take a ferry journey to hospital can claim repayment of travel expenses less the first £10 for each appointment.
2. Patients who are in receipt of benefit listed in Section 5, will not have to pay the first £10.00 of any expenses claimed as long as proof of entitlement can be given. There is no minimum distance to travel to hospital.
3. Payment will not be made without invoices/receipts being submitted, except for mileage claims for travel by car which are paid at the prevailing mileage rate.
4. Further information can be found on NHS Highland website www.nhshighland.scot.nhs.uk or by contacting the cashier at your local hospital.

PLEASE SEND COMPLETED FORMS TO :

Argyll & Bute Patients – NHS Highland Patient Travel Department, AROS, Blarbuie Road, Lochgilphead, PA31 8LB

Highland Council Area Patients – NHS Highland Patient Travel Department, Assynt House, Beechwood Park, Inverness, IV2 3BW

OR Your Local Hospital Cashier