|  |  |  |
| --- | --- | --- |
|  Designated Authority Name: |  ☐ Contribution |  ☐ Non-Contribution |
|  Contact Name: |  Date of Request:  |
|  Phone #: |  Fax #: |
|  Client Name: |  |
|  Date Of Birth: yy/mm/dd  |  Status #:

|  |
| --- |
| PHN# |

 |
|  Referred by: |  Referred to: |
|  Appointment Date: |  Appointment Time: |
|  Travel From: |  Travel To: |
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| Requesting: ☐ Escort ☐ Accommodation ☐ Meals ☐ Mileage ☐ Air/Ferry/Bus/Taxi/Medical Van |

**Travel for dental treatment may be funded by the FNHA, when the dental treatment is being funded by the Health Benefits, Dental Program and meets the following eligibility criteria:** |
| ☐ General Anaesthesia (12 years of age and under)with Full Mouth Treatment being performed under GA, where all necessary treatment requirements are being addressed in one trip | ☐ Access to Orthodontic Services; Approval for Records & Treatment Plan (1 trip); Travel for Approved Orthodontic Treatment |
| ☐ Where a Client has a documented medical condition or handicap which makes treatment in a local private practitioner setting not possible | ☐ Removal of Impacted Teeth |
| ☐ | With approval for treatment from FNHA, Dental Predetermination Unit |
| ☐ Where significant facial trauma requires immediate investigation and treatment beyond the scope of the local provider☐ Other | ☐ | The travel is coordinated with other medical appointments for that client; or The travel is coordinated with other clients travelling for medical appointments to the same location (e.g., medical van travel) |
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**Please fax request along with supporting documentation (e.g., doctor’s referral and treatment plan) to FNHA at: 1-604-666-0292. A copy of the decision should be kept with the client’s file for audit purposes**