



**DEPARTMENT OF HEALTH
Medical Travel Policy - Appendix C**

**Department of Health
Appeal Request Form**

Information from Client, Guardian or Client Escort who was denied a travel benefit or want to request exceptional benefits:

Client Name: _____ Date of Birth: _____
HCP Number: _____ Community & Phone #: _____
Date of this Request: _____ Appointment Date[s]: _____
Date the Appointment was Booked: _____
Reason given for denial: _____

Name of individual/office that denied the claim, if known: _____

This appeal must include the reason or condition for which the benefit was requested.

This is to notify the Department of Health of my intention to appeal a decision made with respect to the benefits associated with travel for the purpose of receiving a health service. I am appealing the decision for the following reason(s):

Attach additional pages, if necessary.

Signature of Client, Guardian, or Client Escort

Contact Number

Email completed appeals to: medicaltravelappeals@gov.nu.ca

To be completed by Medical Travel Appeals Reviewer:

Reason for decision:

<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
_____	Signature
_____	Date

In the event that this appeal is denied, a supplementary appeal may be submitted to the Deputy Minister of Health.