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:

_____

_____

_____

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

☐ Approved ☐ Denied

_____ Signature

_____ Date