JUNE 2024

FOR ADMIN USE – TRAVEL WARRANT	YES / NO

NHS HIGHLAND

HIGHLANDS AND ISLANDS PATIENTS' TRAVEL EXPENSES CLAIM FORM

To use this form please note that you must –

a) live, or be permanently employed, and registered with a GP practice in the NHS Highland area;
b) have incurred the expenses detailed on this form; and
c) have not claimed elsewhere for the expenses detailed on this form.

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

PATIENT'S NAME: ..... CHI NUMBER:.....
OR DATE OF BIRTH

IF PATIENT UNDER 16, PAYMENT TO: .....

ADDRESS: .....

..... POSTCODE .....

DAYTIME TEL NO: ..... EMAIL: .....

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. ……/……/……. ……. : ……. 3. ……/… …../…… ……. : ……..
2. …../… …../… ….. ……. : ……. 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: ……../……../…….. Tel No: .....

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			
	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

SIGNATURE ..... **PRINT NAME:**.....

TO AND FROM HOSPITAL

DESIGNATION..... **TEL NO:** .....

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

SECTION 6: TO BE COMPLETED BY (OR ON BEHALF OF) PATIENT

PLEASE STATE REASON FOR USING TAXI (IF CLAIMED FOR) & PLEASE NOTE THAT TAXIS MUST BE PRE-AUTHORISED BY PATIENT TRAVEL:

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 & Support Allowance / Income-based Job Seeker's Allowance / Pension Credit (Guarantee Credit) / Universal Credit (dependent on take home amount) / NHS Tax Credit Exemption Certificate / HC2 Certificate

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

NHS Highland pay directly into your Bank Account via BACs Transfer, please provide your account details below, together with confirmation of your email address to send remittance advice to:

Sort Code: **Account No:** **Email:**

NB: If no bank details are provided a cheque will be raised and issued, with cheque runs made weekly.

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

I certify that I live, or am permanently employed, and registered with a GP practice 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 understand that the information from this form may be used 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

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 of more than 5 miles, to hospital can claim repayment of travel expenses less the first £10 for each appointment.
2. Patients, who are in receipt of benefit listed above, will not have to pay the first £10.00 of any expenses claimed as long as proof of entitlement can be given and there is no minimum distance applicable 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 and copy of full "Policy for Financial Assistance to Support Travel to and from Hospital" can be found on the NHS Highland website www.nhshighland.scot.nhs.uk or by contacting Patient Travel Dept. on 01463 704902.
5. Further information on how NHS Highland uses your information and the process of Data Protection can be found at www.nhshighland.scot.nhs.uk/Pages/YourRights.aspx

PLEASE SEND COMPLETED FORMS TO:

Argyll & Bute Council Patients – NHS Highland Patient Travel Dept, Kilmory, Lochgilphead, PA31 8RT

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

OR your Local Hospital Cashier

SECTION 7: 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: