New Nouveau Brunswick

Out of Province Hostel Facilities & Meal Allowance Application for Reimbursement

Guidelines

The purpose of this form is to allow eligible New Brunswick residents who receive entitled hospital services outside of New Brunswick to submit claims for accommodations and meals providing they meet certain criteria.

Payment of meals for the patient and/or essential escort requires prior approval from Medicare's Medical Consultant or the NB out of Province Liaison Nurse.

In hostels that provide meals, no extra payments for meals will be made by Medicare to the patient and/or essential escort. If the facility where the patient has been approved to stay does not provide meals, patients and their escort may be reimbursed the amount equivalent to the NB Government out of province meal allowance. Some restrictions may apply and will be assessed on a case by case basis.

For all questions or concerns about this form, please refer to the Medicare website: http://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan.html or you may contact the Medicare Client Advocate at (506) 453-4227, or by email at Medicare.Client.Advocate@gnb.ca.

Patient Information:

Patient Name	N.B. Medicare #	Telephone No.	Date of Birth
		(h) ______________ (c) ______________	DD | MM | YYYY
Escort's Name	**Travel Dates**		**Location of Service** *(city, province)*
	______________ to ______________ (d/m/yyyy) (d/m/yyyy)		

Address

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Payment Information:

1. Meals: Indicate below, total number of meals (no receipts required):

	Meals Provided by Hostel? (YES/NO)	Number of Meals *Dates of visit should match number of meals*			Total Paid (office use only)
		Breakfast	Lunch	Dinner	
Patient					$
Escort (if applicable)					$

2. Accommodations: If payment was made by patient, include **original** Rental/Hotel receipt. $

TOTAL CLAIM: $

3. Agreement: I hereby apply for payment in respect of the cost of medical and/or hospice services on behalf of myself or the above-named patient and certify that the information which I have given is true and correct.

Signature: ______________________ **Date:** ______________

Return Completed Form To:
Medicare New Brunswick
ATTENTION: OOP Hospital Claims
PO Box 5100
Fredericton, NB E3B 5G8