Out-of-Province lodging and meals
Application for reimbursement

Eligible New Brunswick residents who receive entitled medical services provided in an approved hospital facility outside of New Brunswick can submit claims for lodging and meals to New Brunswick Medicare providing they meet certain criteria.

Payment of lodging and meals for the patient and an essential escort requires prior approval from Medicare's Medical Consultant. Medicare will not reimburse fees for lodging and meals associated with out-of-province medical services if those same services are available in New Brunswick.

Medicare will not reimburse patients and escorts for meals in instances where the hostels provide meals. If the facility where the patient has been approved to stay does not provide meals, patients and their escorts may be reimbursed the amount equivalent to the Government of New Brunswick's out-of-province meal allowance. Some restrictions may apply and submissions 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** _____ to _____ (d/m/yyyy) (d/m/yyyy)		**Location of Service** ***(city, province)***

Address

_____

_____

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**	**Diner**	
Patient					$
Escort (if applicable)					$

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

TOTAL CLAIM: $

3. Agreement: I hereby apply for reimbursement of the costs of lodging and meals 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