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| --- | --- | --- | --- | --- | --- | --- |
| Designated Authority Name: | | | | ☐ Contribution | ☐ Non-Contribution | |
| Contact Name: | | | | Date of Request: | | |
| Phone #: | | | | Fax #: | | |
| Client Name: |  | | | | |
| Date Of Birth: yy/mm/dd | Status #:   |  | | --- | | PHN# | | | | | |
| Referred by: | Referred to: | | | | |
| Appointment Date: | Appointment Time: | | | | |
| Travel From: | Travel To: | | | | |
| |  | | --- | | Requesting: ☐ Escort ☐ Accommodation ☐ Meals ☐ Mileage ☐ Air/Ferry/Bus/Taxi/Medical Van |   **Travel for dental treatment may be funded by the FNHA, when the dental treatment is being funded by the Health Benefits, Dental Program and meets the following eligibility criteria:** | | | | | |
| ☐ General Anaesthesia (12 years of age and under)with Full Mouth Treatment being performed under GA, where all necessary treatment requirements are being addressed in one trip | | ☐ Access to Orthodontic Services; Approval for Records & Treatment Plan (1 trip); Travel for Approved Orthodontic Treatment | | | |
| ☐ Where a Client has a documented medical condition or handicap which makes treatment in a local private practitioner setting not possible | | ☐ Removal of Impacted Teeth | | | |
| ☐ | With approval for treatment from FNHA, Dental Predetermination Unit | | |
| ☐ Where significant facial trauma requires immediate investigation and treatment beyond the scope of the local provider  ☐ Other | | ☐ | The travel is coordinated with other medical appointments for that client; or The travel is coordinated with other clients travelling for medical appointments to the same location (e.g., medical van travel) | | |
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**Please fax request along with supporting documentation (e.g., doctor’s referral and treatment plan) to FNHA at: 1-604-666-0292. A copy of the decision should be kept with the client’s file for audit purposes**