NHS
Kernow
Clinical Commissioning Group

Off Island Travel Claim Form

- Claims without an authorisation code provided by Royal Cornwall Hospital will not be processed.
- Claims must be made within three months of date of travel.
- Please return completed form to Patient Transport, NHS Kernow CCG, Sedgemoor Centre, Priory Road, ST AUSTELL, Cornwall. PL25 5AS

Patient's Details	
Surname:	
First Name:	
Title: (Mr/Mrs/Miss/Ms/Other)	
Date of Birth:	Contact Telephone Number:
Address: Postcode:	

Details of Travel	
Authorisation Code provided by Royal Cornwall Patient Transport Booking Office: *(your claim will not be processed without this)*	
Travel Date:	Return Date:
I wish to claim a refund of: **£**	Receipt of transport attached? Yes/No *(claims will only be processed if receipt of travel is provided)*
Escort Required? Yes/No	

Treatment Information	
Name of the doctor, clinician or optician who referred you:	
Name, Address and the telephone number of the hospital or place of treatment.	
Name:	Department Attended:
Address: Postcode:	
Telephone Number:	

Additional Journeys	
Up to three additional journeys can be claimed on this form, please use an additional form if needed.	
Journey 1 – Details of Travel	**Journey 1 – Treatment Information**
Authorisation code:	Name of the doctor, clinician or optician who referred you:
Travel Date:	***Contact details of hospital/place of treatment***
Return Date:	Name:
I wish to claim a refund of: £	Department Attended:
Receipt of transport attached?	Address:
Escort required?	Telephone Number:

Journey 2 – Details of Travel	**Journey 2 – Treatment Information**
Authorisation code:	Name of the doctor, clinician or optician who referred you:
Travel Date:	***Contact details of hospital/place of treatment***
Return Date:	Name:
I wish to claim a refund of: £	Department Attended:
Receipt of transport attached?	Address:
Escort required?	Telephone Number:

Journey 3 – Details of Travel	**Journey 3 – Treatment Information**
Authorisation code:	Name of the doctor, clinician or optician who referred you:
Travel Date:	***Contact details of hospital/place of treatment***
Return Date:	Name:
I wish to claim a refund of: £	Department Attended:
Receipt of transport attached?	Address:
Escort required?	Telephone Number:

Declaration and Signature	
I declare that the information given on this form and the supporting documents are correct and complete and I understand that if I knowingly provide false information my claim may be rejected.	
Signature:	Date: