

**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 NHS Cornwall and Isles of Scilly Part 2S, Chy Trevail, Beacon Technology Park, Dunmere Road, Bodmin PL31 2FR

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

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| **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 |

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| **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:  |

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| **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: |

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| **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: |

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| **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: |

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| **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: |