

**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: |