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CONSEIL CRI DE LA SANTÉ ET DES SERVICES SOCIAUX DE LA BAIE JAMES
CREE BOARD OF HEALTH AND SOCIAL SERVICES OF JAMES BAY

CNIHB

TRAVEL REIMBURSEMENT CLAIM FORM

Date: *year - month - day*

CLAIMANT INFORMATION

Last Name:

First Name:

- ○ Patient
- ○ Caregiver
- ○ Non-JBNQA
- ○ Other:

Address: *civic address, street, postal code, p.o. box*

Date of birth: *year - month - day*

Telephone - home:

Telephone - work:

Telephone - mobile:

Email: **Important for direct deposit*

JBNQA / Beneficiary #:

○ If you are a **patient** and travelling with a caregiver, please provide:

Caregiver's name:

Caregiver's JBNQA/Beneficiary #:

○ If you are a **caregiver**, please provide patient's name:

Patient's name:

Patient's JBNQA/Beneficiary #:

○ If you are a ______________, please provide patient's name:

Patient's name:

Patient's JBNQA/Beneficiary #:

TRAVEL INFORMATION

	Date of arrival *year - month - day*	Travelling from (community)	To (service point)
Trip 1			
Trip 2			

○ **I understand that payment will be made by the Cree Board of Health and Social Services of James Bay**

Signature of the claimant

Date (YYYY-MM-DD)

Reimbursement Method:

- ○ Cheque*
- ○ Direct Deposit
  - ○ Account already opened
  - ○ Void cheque included

** Make sure the cheque is printed with your name on it.*

NB: Direct deposit is the fastest way to receive your money. Ask how you can register for it.

FOR CNIHB OFFICE USE ONLY

	Reimbursement per category	Grand total
Travel		$
Meals		
Lodging		

Validated by:

Date:

Department:

Community:

https://www.creehealth.org/node/9272

FOR ALL INQUIRIES, PLEASE CONTACT 819-855-2744

Please allow a minimum of two weeks after submitting form before calling.