abbvie

HepNS

Hepatitis Outreach Society of Nova Scotia

Do you have Hep C? Do you need financial help with the cost of traveling to Hep C related medical appointments?

While funds last, HepNS is offering a travel reimbursement program to Nova Scotians being treated for Hep C. Listed below are some expenses your reimbursement could help with.

Mileage
Parking

Meals

Hotels

Although the reimbursement will not cover all your costs, HepNS sincerely hopes this support will help. After you and your health care provider fill out the form on the back of this flyer send it to HepNS by mail, email, fax or drop it off to the HepNS office. You can reach out to us for information or even just to chat about how you are feeling. We want to assure you that you're not alone. We are here for you.

Office hours Mon-Friday, 9-4 (If dropping by call ahead to make sure we are open)
5571 Cunard St, Suite 201, Halifax, Nova Scotia B3K 1C5 (up one flight of stairs)
Mailing address: P. O. Box 29120 Halifax, Nova Scotia B3L 4T8
Phone: 902-420-1767 or 1-800-521-0572 Fax: 902-463-6725
Email: program@hepns.ca   www.HepNS.ca
HepNS thanks AbbVie for supporting the Travel Reimbursement project!

To be completed by the person applying for travel reimbursement:

I ________________________________ (clearly print the name of person applying for travel reimbursement) give HepNS permission to contact the health care provider listed on this form to help determine my eligibility for travel reimbursement. I understand that I may not be eligible for the reimbursement and that the reimbursement will not cover all my travel costs. Applications for travel reimbursement will be processed in the order they are received by HepNS. I understand that the program may run out of funds meaning that this claim may not result in a reimbursement.

Signature: ____________________________ Date: ___________________________

Phone number: _______________________ May HepNS leave a voicemail? Yes____ No_____
Email: _______________________________
Circle preferred method of contact: phone or E-mail

May HepNS contact you to complete a survey about this program? Yes _____ No _____
You will still be eligible for travel reimbursement and HepNS services if you answer no to this question.

Your name and personal information will be used solely by HepNS staff in processing the reimbursement. It will not be shared with any health care professionals (except the one listed on this form) or other organizations, including the funder.

To be completed by the health care provider the appointment is with (for example, if the appointment at a Hepatology clinic the doctor or nurse there must complete this form not the family doctor).

Patient's home address____
Address of the Hep C related appointment____
(It is important that the patient home address and appointment address be accurate as travel reimbursement amount is based on this information. Please take the information from the patient file)

Health Care Provider Name: ____________________Title: ______________________________
Name of Organization/Facility: ____
Phone number: ______________________________Email:____________________________
Please fill in this information or add sticker here providing the information. Indicate preferred method of contact: phone or E-mail.

I confirm that__________________________ (clearly print patient name) had a medical appointment in regards to his/her hepatitis on _________________________ (date). I understand that HepNS staff may contact me to confirm information on this form.

Signature: ______________________________ Date: __________________________

For additional forms photocopy this flyer, contact HepNS, or download from the website.