**Travel Cost Refund Scheme - Claim Form**

**Travel costs are refunded are NO LONGER refunded on the day of the appointment, AND ONLY VIA BANK TRANSFER when accompanied by VALID RECEIPTS and CORRECT PROOF OF BENEFITS**

**Please complete form using block capitals and write clearly**

**Part 1**

**Patient’s Details** **Carenote No:** **Postcode**:

**Please tick** First appointment Regular appointment 

Patient’s full LEGAL name ……………………………………………………………………

Date of Birth …………………………………………………………………………………….

Authorised Escort / Guardian name: …………………………………………………………

Escort/Guardian Travel Payment Authorised by Clinician (for over-17s only) - Print name and

sign………………………………..………………………………………….

Department (please circle): CYAF / ADOL / ADULT / GIDS / GIC

**Department Receptionist**

**I confirm that the above patient attended for a clinical appointment as follows:**

Appointment time: ………………… date: ……………………..

Receptionist Signature and stamp

 **Signature:**

**─────────────────────────────────────────────────────**

**Part 2**

**Patient’s Travel Details**

Journey Details…………………………………………………………………

**Mode of transport** - **We cannot refund congestion or parking charges, or Taxi Fares**

Please tick:Tube  Bus  Train  Car 

Cost of **RETURN** journey £…………… In words…………………………….

**PLEASE TURN OVER**

**Patient’s Declaration**

**Please tick as appropriate**

* Income Support
* Income-based Jobseeker’s Allowance
* Income-related Employment and Support Allowance
* Pension Credit Guarantee Credit
* NHS tax credit exemption card/certificate
* Certificate HC2 or HC3
* Universal Credit (Certificate HC5 required)

**If you are unable to tick one of the above descriptions, you are NOT** **automatically entitled to a refund of your travel costs.**

I declare that the information given on this claim form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make an incorrect claim. I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

**Patient or authorised escort signature:** …………………………………….

**MUST BE COMPLETED, OTHERWISE PAYMENT CANNOT BE MADE**

|  |
| --- |
| **BANK DETAILS FOR BACS PAYMENT** |
| **Bank** |  |
| **Account name**  |   |
| **Sort Code** |  |
| **Account number** |  |

FOR OFFICE USE ONLY:

──────────────────────────────────────────────

**Part 3**

**Receptionist -** I certify that the above claim was correctly forwarded to Finance by the undersigned.

Signature: …………………………………………….Date: ………………………

03/06/2020