**Medical Escort Expense Reimbursement Invoice**

The following information is required in order to assess your account.

Invoice #:

**General Information**

|  |  |
| --- | --- |
| Hospital (Claimant) Name and Address: |  |
| Contact Name and Telephone Number: |  |
| Escort Name: |  |

**Patient Information**

|  |  |
| --- | --- |
| Patient’s OHIP No. |  |
| Patient’s Last Name |  |
| Initials |  |
| Patient’s First Name |  |
| Sex | ○M ○ F |
| Date of Birth | DD/MM/YYYY |
| Patients Ontario Address |  |
| Home Telephone No. | ( ) |
| Business Telephone No. | ( ) |
| City, Town |  |
| Province |  |
| Postal Code |  |
| Flight Number |  |
| Patient Number |  |

**Expenses**

|  |  |  |  |
| --- | --- | --- | --- |
| Item Description | Total Expense | Less HST | Total to be Reimbursed |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
| TOTAL |  |  |  |

**Want more information?**

Please contact the Operations Control Centre to speak directly to a Communications Officer

CALL: 1.800.387.4672

You can also visit our Healthcare Provider’s Portal online at: www.ornge.ca/hp