Pediatric Out-of-Province Travel Assistance Program

Prior Approval Request

This form establishes the medical need for a pediatric patient to be referred outside of Saskatchewan to receive medical treatment. The Pediatric Out-of-Province Travel Assistance Program will only review applications when approved by the Provincial Department Head of Pediatrics prior to submission to the Ministry of Health. Submission of a prior approval request does not guarantee approval of travel assistance.

The Ministry of Health is not obligated to reimburse for travel (or other costs) to obtain medical services that have not been previously approved through this process. The Pediatric Out-of-Province Travel Assistance Program (PTAP) sets out the rules and guidelines for the reimbursement and payment of travel, meals and accommodations expenses which are limited to **pediatric patients** (16 year of age and younger) required to travel outside the province to receive medical treatment.

Section A – Patient Information

When completing this section, the **Saskatchewan specialist's office** should verify that the patient's health number, address and phone number(s) are current and correct.

Last Name	First Name	DOB (DD / MM / YYYY)	Health Services Number

Parent/Legal Guardian Last Name	Parent/Legal Guardian First Name

Home Mailing Address	City	Province	Postal Code
		SK	

Contact phone number	Email address (if known)

Section B – Referring Saskatchewan Specialist

Please note: The specialist completing this form must be licensed in **Saskatchewan.**

Please provide your name and a telephone number where you can be reached if there are questions.

Last Name	First Name	Phone

Address	Email (optional)

Section C – Out-of-Province (OOP) Hospital/Physician

Hospital/Facility Name:			Specialty	
Physician			**City**	**Province**
Telephone Number	**Ext.**	**Email Address (optional)**	**Fax**	

Section D – Treatment

Clinical Diagnosis (if applicable)

Recommended medical treatment and/or procedure for which funding approval is requested:

Hospital Admission Date (DD / MM / YYYY)	Hospital Discharge Date (estimate) (DD / MM / YYYY)	Date of OOP Consultation/Treatment (DD / MM / YYYY)	# of nights accommodation

Section E – Treatment Availability (This section confirms the need for the patient to be referred outside of Saskatchewan)

Is this medically required service/treatment an accepted standard of care?	❑ Yes	❑ No
Is this medically required service/treatment available in Saskatchewan?	❑ Yes	❑ No

Section F – Declaration

As the referring physician, I declare that the information provided on the form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Once completed, please submit this form to Peds.TAP@saskhealthauthority.ca

Please note that if services are deemed available in Saskatchewan, healthcare providers can still refer a patient out of province. However, the patient will not qualify for the Pediatric Travel Assistance Program.

INTERNAL USE ONLY – ***do not complete***

TO BE COMPLETED BY SASKATHEWAN HEALTH AUTHORITY

Provincial Head of Pediatrics Recommendation:

RECOMMENDATION: ☐ Recommended ☐ Not Recommended

Provincial Head of Pediatrics _____ _____
Signature Date

Forms signed by the Provincial Head of Pediatrics can be emailed to: TravelAssistanceProgram@health.gov.sk.ca

TO BE COMPLETED BY THE MINISTRY OF HEALTH

Ministry Medical Consultant Recommendation:

RECOMMENDATION: ☐ Recommended ☐ Not Recommended

Medical Consultant _____ _____
Signature Date

Director Insured Services Recommendation:

RECOMMENDATION: ☐ Approved ☐ Denied

Director Insured Services _____ _____
Signature Date