Aevitae
Postbus 2705
6401 DE Heerlen

Application form for travel assistance

Explanation

You can use this form to apply for travel assistance.
Check the appropriate box on the side to make a first application or an extension request.
Enter your personal details and have your referring practitioner fill in their part. Check that all required questions are answered and your referring practitioner has signed and dated the form. Only fully completed forms will be processed. You can submit this form to us by using the contact information at the top and the bottom of this form. In response we will send you a written approval or rejection.

○ 1st application
○ extension request

Patient details (to be filled in by the insured)

Name: _____ Initial(s): _____ Preposition(s): _____

Address: _____ House number: _____ Addition: _____

Postal code: _____ City: _____

Policy number: _____ Date of birth: _____ BSN: _____

Phone number: _____ Email address: _____

Question 1 t/m 8 must be filled in by a general practitioner or medical specialist

1 Please select one and answer applicable questions below:

○ The insured must undergo kidney dialysis
○ The insured must undergo cancer treatments with chemotherapy, immunotherapy or radiotherapy
○ The insured can only move using a wheelchair and has no adapted transport:
What is the maximum walking distance (using an aid)? ____ meter
Does the insured rely on a wheelchair permanently? ○ Yes ○ No, the insured is estimated to rely on a wheelchair for ____ months
○ The insured is visually impaired and cannot travel independently or without supervision:
Is the field of vision <20 degrees? ○ Yes ○ No The visual measurement is: Right eye: ___ ___ Left eye: ___ ___
○ The insured needs transport for geriatric rehabilitation
○ The insured needs transport to a nursery daycare
○ The insured must be treated several times per week / month for a longer period of time:

	Destination 1	**Destination 2**	**Destination 3**
Number of months that the treatment will last:	___ ___	___ ___	___ ___
Number of kilometers from home to treatment address, one way:	___ ___ ___	___ ___ ___	___ ___ ___
Average number of days that the insured needs transport, due to the treatment:	___ ___ per week ___ ___ per month	___ ___ per week ___ ___ per month	___ ___ per week ___ ___ per month

○ The insured is an organ donor

2 a Why does the insured need transport? What is the medical indication?

2 b What treatment does the insured need? Or is it a doctor's appointment?

3 a To which healthcare provider will the insured be transported?

Please fill in the healthcare provider's name, address, postal code and city:

3 b Is this treatment covered by the basic healthcare insurance? ○ Yes ○ No

3 c Does the transport concern children who need to combine (part-time) treatments with school attendance?

○ Yes ○ No If "yes", please fill in the table below:

	Monday	Tuesday	Wednesday	Thursday	Friday
Regular school hours					
Time of treatment					
Time of treatment					
Time of treatment					

Is there a claim to student transport? ○ Yes ○ No

If "no", why is there no entitlement to student transport?

4 What is the estimated treatment period? Start date: __ __ - __ __ - __ __ __ __ End date: __ __ - __ __ - __ __ __ __

5 Is the insured able to travel by own transport? ○ Yes ○ No

6 Is the insured able to travel by public transport? ○ Yes ○ No

7 Can the insured only make use of taxi transport? ○ Yes ○ No

If "yes", please elaborate:

8 Does the insured require an escort during transport? ○ Yes ○ No

The information provided is complete and correct

Name of general practitioner or medical specialist:

Postal code: City:

AGB-code (general practitioner/medical specialist):

Date: __ __ - __ __ - __ __ __ __

Signature and stamp of general practitioner or medical specialist:

To be filled in by the insured:

The information provided is complete and correct

Signature of the insured: Date: __ __ - __ __ - __ __ __ __

Submit the fully completed and signed form to Aevitae:

- Upload through the online environment (Mijn Aevitae)
- Our email address: mg@aevitae.com
- Our postal address: **Aevitae**
  Postbus 2705
  6401 DE HEERLEN

Based on the information on this form, Aevitae determines whether there is a right to travel assistance, and if so, for which mode of transport and for what duration and frequency. You will receive a written authorization or rejection. Aevitae reserves the right to carry out checks on the transport. If transport costs have been wrongly reimbursed, the wrongful payment(s) may be reclaimed according to the provisions of the Civil Code.