wcb Workers' Compensation Board – Alberta
P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780 427-5863
1-800-661-1993

C727B

HOME HEALTH CARE SERVICES

Travel Plan Authorization Request

WORKER DETAILS					***Please print clearly or type.***	WCB Claim Number
Worker's Surname	First Name and Initial			Date of Birth *(yyyy/mm/dd)*		Date of Accident *(yyyy/mm/dd)*
Address		City/Town	Province	Postal Code		Telephone Number

Claim Owner's Name	Telephone Number
Provider's Name	Telephone Number
Assessment Date *(yyyy/mm/dd)*	Submission Date *(yyyy/mm/dd)*
Primary Travel Plan ☐ Period of Travel Required:	Secondary Travel Plan ☐ * for temporary (<1 year) changes to long-term care plans only Period of Travel Required:

Travel Plan	☐ Outside of city required (one way)	From:	To:	Total KM	Total Travel Time
Anticipated Weekly Totals			Total Weekly Return KM		Total Weekly Travel Time HCA: LPN: RN:
Maximum Proposed Monthly Total			Total Monthly Return KM		Total Monthly Travel Time HCA: LPN: RN:

Description of Travel Needs:

RN Coordinators Name:	Telephone Number:	Fax Number:

_____ _____

RN Coordinator's Signature | Date Signed (yyyy/mm/dd)

Claim Owner: The provider must receive a copy of the Home Care Plan authorization letter. For any travel over 3hrs daily, please contact HCS for approval.

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.
PLEASE INCLUDE THIS REPORT WITH MONHLY INVOICE AND FAX TO 780-427-5863