HollandZorg
No borders to security

Application form for seated patient transport

HollandZorg Munsterstraat 7
Postbus 166
7400 AD Deventer
Customer service (0570) 687 123
on weekdays
between 8.00 hours and 19.00 hours
and on Saturday
between 9.00 hours and 13.00 hours

E-mail info@hollandzorg.nl
Internet www.hollandzorg.nl

Open on weekdays between 8.00 and 17.00 hours

Applicant

Name of insured party: .....

Address: .....

Postcode/city: .....

CSN: ..... Date of birth: .....

Phone number (home): ..... Phone number (work): .....

E-mail: .....

If you are being transported from an address other than your residential address, please indicate below:

Name of care provider or nursing home: .....

Address: ..... Postcode/city: .....

Explanation
To be eligible for reimbursement, you first have to ask for permission from HollandZorg. This application enables HollandZorg to assess if you qualify for reimbursement of seated patient transport. We also determine what type of transport you are given and during which period. The transport should take you to an institution or care provider where you will be treated, which you can invoke by virtue of the Health Insurance Act or the Long-Term care act (Wlz). Please return the fully completed form to HollandZorg or send it to toestemming@eno.nl. **Forms not completed in full will not be dealt with.**
HollandZorg will send you an authorisation form. HollandZorg will notify you in the event your application is denied.
You must notify HollandZorg of all changes that may affect your application or authorisation form, such as a temporary change of nursing address. HollandZorg reserves the right to carry out checks. When transport has been wrongfully reimbursed, the reimbursement will be claimed back by virtue of the Netherlands Civil Code.

To be completed by the insured (please complete the entire form)

1. Kidney dialysis
Do you receive treatment at a kidney dialysis centre?
☐ yes ☐ no

2. Radiotherapy, immunetherapy or chemotherapy
Do you receive radiotherapy, immunetherapy or chemotherapy for a malignant illness?
☐ yes ☐ no
When does the radiotherapy, immunetherapy or chemotherapy start? .....

How many months in total will the treatment last? .....

3. Wheelchair transport
Are you permanently wheelchair-bound?
☐ yes ☐ no provide more details if necessary .....

Is use of the wheelchair temporary? ☐ no ☐ yes, until .....

4. Restricted eyesight
Is your eyesight so poor, you cannot travel by public transport or car without assistance? ☐ yes ☐ no
Is your field of vision restricted? ☐ yes ☐ no

5. Intensive paediatric care
Is the insured person younger than 18 and dependent on care on account of a complex somatic issue or a physical handicap?
☐ yes ☐ no

6. Do you rely on geriatric rehabilitation care? ☐ yes ☐ no

7. Would you like to use the opportunity of overnight stays? ☐ yes ☐ no

8. Long-term illness or disorder (Only complete if you answered no to questions 1 to 6)
Are you receiving treatment for a long-term illness or disorder?
☐ yes ☐ no
What illness or disorder do you suffer from? .....

How many months will the treatment last (in weeks)? .....

How many times a week will you need treatment? .....

How many kilometre per single trip do you have to travel to receive treatment? .....

7. Transport (TO BE COMPLETED AT ALL TIMES!)
What is the first day of transport? .....

Can you travel by your own transport?	☐ no	☐ yes		
Can you travel by public transport?	☐ no	☐ yes ➪ Do you need an assistant from a medical point of view?	☐ yes	☐ no
Can you travel alone by taxi?	☐ no	☐ yes ➪ Do you need an assistant from a medical point of view?	☐ yes	☐ no
Is this a normal taxi?	☐ no	☐ yes		
Is this a wheelchair taxi?	☐ no	☐ yes		
In the case of intensive paediatric care	parent(s)		(district)nurse	
Who provides guidance to the child?	☐ yes	☐ no	☐ yes ☐ no	
Is combined transport an option?	☐ yes	☐ no, because		

Do you receive an authorisation form from HollandZorg and want to be fully reimbursed for seated patient transport?
In that case, you need to select a taxi firm contracted by HollandZorg.

What is the transport destination?

Name and address of practitioner (multiple destinations possible).	How often per month?
1.	.....
2.	.....
3.	.....

HollandZorg will treat your personal details confidentially.

Completed truthfully

Name of insured party: Date:

Location: Insured party's signature:

Send this form to: HollandZorg
afdeling Declaratie-vervoer
Postbus 166
7400 AD Deventer
E-mail: toestemming@eno.nl

To be completed by doctor in attendance

The above details are correct. ☐ yes ☐ no

This patient requires assistance for seated patient transport for medical reasons. ☐ yes ☐ no
The following diagnosis is of importance in order to qualify for seated patient transport:

More details, if applicable:

If the patient has poor vision, what is the vision measurement: left eye right eye

I agree with the insured party's details given.
AGB code/stamp or BIG registration no./stamp: Signature