

### 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@salland.nl](mailto:toestemming@salland.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, immunotherapy or chemotherapy

Do you receive radiotherapy, immunotherapy or chemotherapy for a malignant illness?

yes  no

When does the radiotherapy, immunotherapy 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. Do you rely on daycare treatment that is provided in a group?  yes  no

**9. 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? .....

**10. 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: <input type="text"/>	Date: <input type="text"/>
Location: <input type="text"/>	Insured party's signature: <input type="text"/>

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