First Nations Health Authority
Health through wellness

# FNHA CLIENT REIMBURSEMENT REQUEST FORM

Information you need to include with your completed client reimbursement form can be found on the next page of this form. **Please note** that all FNHA policies and requirements for coverage apply. **All requests for reimbursement of eligible benefits must be made within one year from the date of service.**

**It is important to submit ALL related documents or there will be a delay in processing your claim. Please keep copies for your files.**

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Under the First Nations Health Authority (FNHA), eligibility for the FNHA Health Benefits program extends to include all First Nations people that are resident of British Columbia and have a status number (excluding persons who receive health benefits by way of a First Nations organization pursuant to self-government agreements with Canada).

- Residency in BC is defined as having an active BC Services Card (Care Card) and living in BC.
- Non-resident First Nations using health services in BC will continue to be covered by Health Canada through the Alberta NIHB Regional office.

**Part 1 – Client Information** (client receiving the service)

| | |
|---|---|
| Surname: | First and Middle Names: |
| Address: Apt.: | Identification Number: |
| City: Province/Territory: | Telephone number: ( ) |
| Postal Code: | Date of Birth: PHN:<br>/ /<br>(YYYY/MM/DD) |
| Are you covered for any of these expenses under any other health plan(s)/program(s)? **No** ❑ **Yes** ❑<br>**If yes**, please attach a copy of a detailed statement or explanation of benefits form from all other plan(s)/program(s). | |

**Part 2 – Parent, Guardian or Person to whom payment should be made**
Please provide the name and address of the person to whom payment should be made if different from client receiving the service. If client is under one year of age and not registered, please provide parent or guardian information. The person must also be over the provincial/territorial legal age.

| | |
|---|---|
| Surname: | First and Middle Names: |
| Address: Apt.: | Identification Number (if applicable): |
| City: Province/Territory: | Telephone number: ( ) - |
| Postal Code: | Date of Birth: PHN:<br>/ /<br>(YYYY/MM/DD) |
| Relationship to Treated Client: | |

**Part 3 – Details of Claim**
Instructions on what information is needed to be included with the completed client reimbursement form are listed on the next page. Fill in the total of **all** receipts for each category.

| **List Benefit Items Requested:** (Prescription drugs or Medical Transportation Benefits) | **Cost** |
|---|---|
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| | |
| **TOTAL AMOUNT CLAIMED:** | |

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**Part 4 – Authorization and Signature** (Mandatory)

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to FNHA, its agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by Health Canada and/or FNHA or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits. By signing below, I also authorize FNHA to collect information from my medical provider for services provided to me and paid for by the Health Benefits Program.

| **Client, Parent, Guardian or Person having a legally recognized authority** | **Date:** / / (YYYY/MM/DD) |
|---|---|
| **Print Name:** | **Signature:** |

**Forms that are not signed will be returned to the client for signature.**

**Privacy statement**
FNHA is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the FNHA Health Benefits Program collects, uses, discloses and retains your personal information in accordance with the applicable privacy laws and policies. Further details of the FNHA Health Benefits Program can be found on the website www.FNHA.ca

## INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

- Original receipt(s) for proof of payment, e.g. official pharmacy receipts (provided by your pharmacy with each prescription purchased). Credit card/Debit (Interac) slips are not acceptable forms for proof of payment.
- If applicable, submit your detailed statement or explanation of benefits form from all other health plan(s)/program(s). Note: Original receipts are not required when submitting the detailed statement or explanation of benefits form as the primary insurer requires them. In such cases, a copy of the original receipt is acceptable.
- Medical Transportation – confirmation of attendance signed by physician/health facility

## MAILING INSTRUCTIONS

**For all reimbursements, please mail your completed form(s) and receipt(s) to the FNHA Health Benefits Office at the following address:**

First Nations Health Authority
Health Benefits
540-757 West Hastings Street
Vancouver, British Columbia V6C 1A1