First Nations Health Authority
Health through wellness

Mental Health Counselling
Prior Approval Form

Please submit a completed copy of this form by fax or mail.

Health Benefits Fax #: 604.658.2833

Mailing Address: First Nations Health Authority
HB Mental Health Program
540 – 757 West Hastings St
Vancouver, BC V6C 1A1

DO NOT E-MAIL prior approval requests to FNHA, as they contain confidential client information and identifiers.

The Health Benefits Program provides coverage for counselling services through the Mental Wellness and Counselling Program, the Indian Residential Schools Resolution Health Support Program, the Missing & Murdered Indigenous Women & Girls Health Support Services Program, and the Indian Day Schools Health Support Services Program. For billing purposes, FNHA staff will determine the appropriate mental health counselling program for the client.

Providers must receive prior approval before delivering services in order to be eligible for payment. Only providers who are registered with the Health Benefits Program can request prior approval for counselling services. Prior Approvals for the Mental Wellness and Counselling Program, the Missing & Murdered Indigenous Women & Girls Health Support Services Program, and the Indian Day School Health Support Services Program are valid for 22 hours of counselling over a 12-month period Prior Approvals for the Indian Residential Schools Resolution Health Support Program are valid for 62 hours of counselling, with no expiry date. When the approved hours have been used - or the approval expires - a new Prior Approval
Form must be submitted in advance of further sessions. Treatment should start within two weeks of the FNHA's approval.

The service standard for FNHA to process prior approvals is 15 business days. Incomplete or illegible forms will not be accepted. In such cases, you will be notified and asked to submit a revised version which may delay approval.

To follow up on submitted prior approval forms, please call 1.877.477.0775.

SECTION A - PROVIDER INFORMATION

NAME OF PROVIDER *(Please do not use the organization's payee name)* PHONE NUMBER

ADDRESS CITY

PAYEE (*If different from name of provider)*

SECTION B CLIENT INFORMATION

Is this the first prior approval this provider has submitted for this client? ☐ YES ☐ NO

NAME OF CLIENT DATE OF BIRTH (YYYY / MM / DD)

ADDRESS

CLIENT'S INDIAN STATUS NUMBER (FOR FIRST NATIONS) PHONE NUMBER

PERSONAL HEALTH NUMBER (PHN)

Is the client eligible for counselling coverage from any other insurance plan or public program? ☐ YES ☐ NO

If the client is seeking services regarding the issue of Missing & Murdered Indigenous Women & Girls, please describe:

____

If applicable, indicate if the client is a:

- ☐ Former Indian Residential School student
- ☐ Family member of a former Indian Residential School student
- ☐ Former Indian Day School student
- ☐ Family member of a former Indian Day School student

NAME OF FORMER STUDENT RELATIONSHIP TO CLIENT (IF APPLICABLE)

FORMER STUDENT'S DATE OF BIRTH: (YYYY/MM/DD) NAME OF SCHOOL ATTENDED

SECTION C – PROVIDER ACKNOWLEDGMENT:

- I have developed (or for a new client, will develop) a treatment plan for this client in accordance with the requirements of my professional body, and I have discussed (or for a new client, will discuss) the recommended treatment with the client;
- My practice aligns with the terms and conditions for the provision of counselling services outlined in the Mental Health Counselling Provider Agreement, and I agree to not charge the client for any services provided;
- I have informed my client whether they may be responsible to pay me directly for any missed counselling appointments;
- I have explained the terms and conditions of mental health benefits provided by the FNHA Health Benefits Program to the client;
- I have informed the client that they can make a complaint to my professional body if they have concerns about my services;
- I will keep records of all appointments with this client, including dates and times, and confirmation of attendance;
- I will cooperate with the FNHA in the occurrence of any audit activities by providing supporting documentation to the First Nation Health Authority as outlined in the FNHA Mental Health Provider Agreement, if requested.

SIGNATURE OF PROVIDER DATE (YYYY/MM/DD)

PRIVACY NOTICE:

The personal information you provide to FNHA is governed in accordance with the Personal Information Protection Act ("PIPA") in British Columbia. We only collect the information we need to administer mental health counselling services authorized under the Health Benefits Program or Indigenous Services Canada.

Purpose of collection: We require your personal information to consider you for enrollment as a provider of these services.

Other uses or disclosures: In limited and specific situations, your personal information may be disclosed without your consent in accordance with section 18 of the Personal Information Protection Act ("PIPA") in British Columbia.

Your rights under PIPA: In addition to protecting your personal information, PIPA gives you the right to request access to and correction of your personal information. You also have the right to file a complaint with the Office of the Information and Privacy Commissioner of B.C. if you think your personal information has been handled inappropriately.

For more information about privacy, please contact the Privacy Office of the FNHA at privacy@fnha.ca.