

## NIHB GENERAL MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

**Section 1: Client Information**

Surname:		Date of Birth: (YYYY/MM/DD)	
Given Name(s):		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
Street Address:		City:	
Province/Territory:		Postal Code:	
Client ID #:	[OR] Band #:	Family #:	

**Section 2: Parent/ Legal Guardian/ Representative**

If client is under one year of age and not registered, please provide parent's information.

Surname:		Given Name:		Date of Birth: (YYYY/MM/DD)	
Client ID#:		[OR] Band #:		Family #:	

**Section 3: Prescriber Information (PLEASE PRINT)**

Name and Title:		License / Billing #:	
Telephone #:		Fax #:	

**Section 4: Client Health Information**

Diagnosis:
Explanation of benefit requirement and specific details of item to be provided (MUST BE COMPLETED):
* Any additional information that supports this request can be attached to this form on a separate sheet so as not to delay the review of this request.
Is the benefit requested due to the result of an injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:
Where did the injury occur? Home <input type="checkbox"/> Work <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other <input type="checkbox"/> When did the injury occur?
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient living in a long term care facility? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section 5: Equipment or Supplies Requested**

Item Description	Benefit Code	Quantity	Actual Acquisition Cost	Mark-Up	Total Cost	Manufacturer Name, Item Code # and Type (If applicable)

**Section 6: Provider Information (PLEASE PRINT)**

Name and Title:		Provider #:	
Telephone #:		Fax #:	
I hereby certify that the information provided above is true and complete. The NIHB Program reserves the right to request this form for audit purposes.			
Provider Signature:		Date:	

**Privacy statement**

Health Canada also requires your authorization in order to collect information from your provider for services provided to you and paid for by the Non-Insured Health Benefits Program. The NIHB Program 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 NIHB Program collects, uses, discloses and retains your personal information in accordance with the applicable federal privacy laws and policies. Further details of the NIHB Privacy Code can be found on Health Canada website: [http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/priv/2005\\_code/index-eng.php](http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/priv/2005_code/index-eng.php).