NIHB GENERAL MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Section 1: Patient Information

Patient's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:

Section 2: Prescriber Information

Prescriber's Name:	License / Billing #:
Telephone #:	Fax #:

Section 3: Client Health Information

Diagnosis:
Explanation of benefit requirement and specific details of item to be provided (MUST BE COMPLETED):
Is the benefit requested due to the result of an injury: Yes ☐ No ☐ If **yes**, please complete the following: Where did the injury occur: Home ☐ Work ☐ Other ☐ When did the injury occur: Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

Section 4:Equipment or Supplies Requested

Description of Device	Benefit Code	Qty	Cost	

Section 5: Provider Information

Provider Name:	Provider #:
Telephone #:	Fax#:
I hereby certify that the information in Sections 4 and 5 is true and complete.	
Provider Signature:	Date:

FOR NIHB OFFICE USE ONLY

P. A.#:	User ID#:
Office Telephone #:	Office Fax #: