

Nova Scotia Diabetes Assistance Program Reimbursement Form

(Please Complete one Form per Patient)

PATIENT INFORMATION				
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
			Relationship to Contact Person (circle one)	
			Self / Spouse / Child / Other	
Health Card Number:			Birth date: (D) (M) (Y)	
Mailing address			Telephone no.: () ()	
P.O. box:				
Street:	City:	Province:	Postal Code:	

CLAIM INFORMATION							
#	DATE OF SERVICE			NAME OF PRESCRIPTION	D.I.N.	AMOUNT CLAIMED	
	DD	MM	YY				
1						\$	
2						\$	
3						\$	
4						\$	
5						\$	
6						\$	
7						\$	
8						\$	
9						\$	
10						\$	
11						\$	
12						\$	
13						\$	
14						\$	
15						\$	
16						\$	
17						\$	
18						\$	
19						\$	
20						\$	
ENTER TOTAL CLAIM AMOUNT						>	\$

PATIENT STATEMENT OF ACKNOWLEDGEMENT AND CONSENT *	
Are you entitled to receive comparable benefits from any other insurance company or Health benefits company or plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete the next block	Name of Insurance Company or Health benefits company or plan:
<p>I certify that the information contained in this and other documents supporting this claim is complete and true for whom this claim is made is an eligible member under the NSDA Program. By submitting this form I understand that I request payment for the listed expenses, in accordance with the Program guidelines. I understand that the expenses listed may not be covered by, or may exceed, the program benefits.</p> <p>I understand that the personal information provided herein, as well as any other personal information currently held by the NSDAP about the eligible member will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer the NSDA Program.</p> <p>I understand that my personal information will be kept confidential and secure</p>	
_____ <i>Signature of Contact Person:</i>	_____ <i>Date:</i>