Health Canada Santé Canada

Canada

Medical Supplies and Equipment Health Provider Information - Resources and Forms

Table of Contents

Provider Inquiries - Contact Information

First Canadian Health …….. ii
Non-Insured Health Benefits Directorate…….. …….. iii
Prior Approvals and Predeterminations Toll Free Lines….. iii
Non-Insured Health Benefits Regional Offices…… v

Forms and Information Products

Dental Benefits …… viii
Drug Benefits…….. ……. x
Eye and Vision Care Benefits…….. xi
Medical Supplies and Equipment Benefits ……..……... xi
Medical Transportation Benefits…… ……..... xii

Forms

Hearing Aid and Hearing Aid Repair Confirmation Form
Hearing Aid and Hearing Aid Repair Prior Approval Request Form
General Medical Supplies and Equipment Prior Approval Form
Prior Approval Form Orthotics - Custom Footwear Prosthetics - Pressure Garments
Oxygen and Respiratory Program Prior Approval Form
Sample Modifications to Pharmacy/MS&E Information form.
Sample Medical Supplies and Equipment Claim Form
Client Reimbursement Request Form
Sample Medical Supplies and Equipment Claim Statement
Sample Medical Supplies and Equipment Prior Approval Confirmation Letter

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This section contains contact information for provider inquiries, as well as forms and information products such as: sample forms; descriptions of reports, publications and other useful information products.

Provider Inquiries

Health Canada:

- For general information about the First Nations and Inuit Non-Insured Health Benefits (NIHB) program and services, contact the Non-Insured Health Benefits Directorate.

- For provider information about NIHB client and benefit eligibility, client reimbursement and appeal procedures, contact your Non-Insured Health Benefits Regional Office.

- Pharmacy providers requesting prior approval of drug benefits may contact the NIHB Drug Exception Centre.

- Dental or Medical Supplies and Equipment providers requesting predeterminations and prior approvals may call their respective NIHB Prior Approval and Predetermination toll-free lines.

First Canadian Health:

First Canadian Health (FCH) is contracted to administer Health Information and Claims Processing Services for dental, medical supplies and equipment (MS&E) and pharmacy benefits on behalf of Health Canada . All NIHB providers submit claims for payment to FCH for NIHB dental, MS&E and pharmacy services/benefits provided to First Nations and Inuit clients.

- **General Information**
  Providers with general information requests should direct their written inquiries to:
  First Canadian Health
  Non-Insured Health Benefits Provider Relations Department
  3080 Yonge Street, Suite 3002
  Toronto, Ontario
  M4N 3N1

- **NIHB Toll-Free Inquiry Centres**
  - NIHB **Dental** and **MS&E** Toll-Free Inquiry Centre: 1-888-471-1111
    Dental and MS&E Providers may contact FCH at this toll-free number for general information, client eligibility, benefit eligibility, and billing and payment information. **Important:** Please have your Provider ID Number ready when calling.
  - NIHB **Pharmacy** Toll-Free Inquiry Centre: 1-888-511-4666
    Pharmacy Providers may contact FCH at this toll-free number for general information, client eligibility, benefit eligibility, and billing and payment information. **Important:** Please have your Provider ID Number ready when calling.

- **Audit Program**
  All NIHB providers requiring additional information about the FCH /NIHB Provider Audit Program may contact the FCH **Director of Provider Audit** in writing by fax at 1-888-276-9848.

- **Verification of client eligibility**:
  All NIHB providers may verify client eligibility in advance of providing services by contacting the appropriate NIHB Toll-Free Inquiry Centre.

  In order to verify client eligibility, the FCH Customer Service Representative (CSR) will require the provider identification number, the client's surname, given names, date of birth, and client identification number.

  If the CSR cannot verify the client, the **client** should be referred to for:

  - **Eligible First Nations clients**, their Band Office or the Registration Services Unit of Indian and Northern Affairs Canada (INAC) at (819) 953-0960;
  - **Inuit residing in the Northwest Territories and Nunavut**, their respective territorial Department of Health and Social Services; and
  - **Inuit residing outside of the Northwest Territories and Nunavut**, the nearest FNIHB Regional Office.

Contact the Non-Insured Health Benefits Directorate

Learn more about our commitment to privacy.

Non-Insured Health Benefits Directorate
First Nations and Inuit Health Branch
Health Canada
Jeanne Mance Building, Tunney's Pasture
Postal Locator 1919A
Ottawa, Ontario
K1A 0K9

Telephone: (613) 954-8825
E-mail: fnihb-dgspni@hc-sc.gc.ca

Contact the Non-Insured Health Benefits (NIHB)

Prior Approvals and Predeterminations Toll Free Lines

Dental
Drug Exception Centre
Medical Supplies and Equipment
Orthodontic Review Centre

Learn more about our commitment to privacy.

Dental

Dental Predetermination Requests Only
(Contact information by province from west to east)

Pacific	1-888-321-5003
Alberta	1-888-495-2516
Saskatchewan	1-877-780-5458
Manitoba	1-877-505-0835
Ontario	1-888-283-8885
Quebec	1-877-483-5501
Atlantic	1-800-565-3294
Yukon	1-888-332-9222
Northwest Territories and Nunavut	1-888-332-9222

Orthodontic Review Centre

Orthodontic providers wishing to submit a treatment plan for prior approval to Health Canada and require help, are encouraged to contact Health Canada's toll-free Orthodontic Review Centre:

Telephone:	1-866-227-0943
Fax:	1-866-227-0957

Drug Exception Centre

Providers requesting prior approval of drug benefits on behalf of NIHB recipients may call Health Canada's NIHB Drug Exception Centre:

Telephone (toll-free):	1-800-580-0950
Telephone (Ottawa):	(613) 941-1558
Fax:	1-800-281-5021

Recipients can mail their appeal request to the following address:

NIHB Drug Exception Centre
First Nations and Inuit Health Branch
Health Canada
Graham Spry Building
250 Lanark Avenue, 6th Floor
Postal Locator 2006B
Ottawa, Ontario
K1A 0K9

Medical Supplies and Equipment

Medical Supplies and Equipment Prior Approval Requests Only
(Contact information by province from west to east)

Pacific	1-800-665-2289
Alberta	1-800-232-7301
Saskatchewan	1-800-667-3515
Manitoba	1-800-665-8507
Ontario	1-800-881-3921
Quebec	1-877-483-1575
Atlantic	1-800-565-4446
Yukon	1-867-667-3974
Northwest Territories and Nunavut	1-888-332-9222

Contact the Non-Insured Health Benefits Regional Offices

Learn more about our commitment to privacy.

Contact information by province from west to east:

Pacific Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
757 West Hastings Street, Suite 540
Vancouver, British Columbia
V6C 3E6

Telephone: (604) 666-3331
Toll-free: 1-800-317-7878

Alberta Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
9700 Jasper Avenue, Suite 730
Edmonton, Alberta
T5J 4C3

Telephone: (780) 495-2703
Toll-free: 1-800-232-7301

Saskatchewan Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1920 Broad Street, 18th Floor
Regina, Saskatchewan
S4P 3V2

Telephone (toll-free): 1-877-780-5458

Manitoba Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
391 York Avenue, Suite 300
Winnipeg, Manitoba
R3C 4W1

Telephone: (204) 983-8886
Toll-free: 1-800-665-8507

Ontario Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1547 Merivale Road, 3rd floor
Postal Locator 6103A
Nepean, Ontario
K1A OL3

Telephone: (613) 952-0093
Toll-free: 1-800-640-0642

Quebec Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
Guy-Favreau Complex, East Tower, Suite 216
200 René-Lévesque Boulevard West
Montreal, Quebec
H2Z 1X4

Telephone (toll-free): 1-877-483-1575

Atlantic Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1505 Barrington Street, Suite 1816
Halifax, Nova Scotia
B3J 3Y6

Telephone: (902) 426-2656
Toll-free: 1-800-565-3294

Contact information by territory from west to east:

Yukon Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
300 Main Street, Suite 100
Whitehorse, Yukon
Y1A 2B5

Telephone: 1-867-667-3942

Northwest Territories and Nunavut

Non-Insured Health Benefits
Northern Secretariat
First Nations and Inuit Health Branch
Health Canada
60 Queen Street, 14th floor
Postal Locator 3914A
Ottawa, Ontario
K1A 0K9

Telephone (toll-free): 1-888-332-9222

Visit our First Nations and Inuit Health section to learn about Health Canada's Non-Insured Health Benefits.

Forms and Information Products

Dental Benefits
Drug Benefits
Eye and Vision Care Benefits
Medical Supplies and Equipment Benefits
Medical Transportation Benefits

Claim Submission Checklist

Providers must address the following points to ensure efficient processing:

I have included the following required **client identification information**:

- **Eligible First Nations**
  - Surname (registered);
  - Given Names (registered);
  - Date of Birth (DD/MM/YYYY); and
  - Indian and Northern Affairs Canada (INAC) Registration Number (also known as DIAND, Treaty or Status Number); or
  - Band Number and Family Number; or
  - First Nations and Inuit Health Branch (FNIHB) Number.

- **Recognized Inuit**

  - Surname;
  - Given Names;
  - Date of Birth (DD/MM/YYYY); and
  - FNIHB Number; or
  - Government of North West Territories or Government of Nunavut Health Care Number.

Dental providers:

- My submission addresses pre-verification/predetermination requirements as outlined in the NIHB Program.
- I have verified that the client is an eligible NIHB client.
- I have completed questions concerning third party coverage, and noted missing teeth as required.
- Where I have indicated that the client has third party coverage, I have attached an EOB form describing third party payment to my claims/post approvals or orthodontic predetermination submission.
- I have reviewed the submission to ensure that all information associated with the date of service, procedure code, international tooth code, tooth surface, professional fee, laboratory fee (if applicable), total fee and predetermination/pre-verification number has been completed.

Pharmacy providers:

- My submission addresses prior approval requirements as outlinend in the NIHB Program.
- I have verified that the client is an eligible NIHB client.
- I have verified whether or not the client has an alternate coverage.
- A prescription for each benefit item to be dispensed has been received.
- All benefit eligibility requirements are met.
- Client is not eligible for coverage from any other source for the benefit requested.
- FNIHB prior approval has been obtained for each item indicated on the NIHB Benefit Lists as requiring prior approval

I have contacted the NIHB Toll-Free Inquiry Centre for answers to any questions regarding client eligibility, and frequency limitation.

Important:
The sample versions of the documents are not forms; they display the information as found on the forms for viewing purposes only and will not be accepted if used to apply to the NIHB program.

All of the forms listed below can be obtained by contacting the NIHB Toll-Free Inquiry Centre.

Some of the following hyperlinks are to sites of organizations or other entities that are not subject to the Official Languages Act. The material found there is therefore in the language(s) used by the sites in question.

Dental

When requesting funding for dental benefits to the Non-Insured Health Benefits (NIHB) Program, providers may use one of the following forms depending on the services required.

Information on the forms is available in both HTML and Portable Document Format (PDF).

The HTML versions of the forms are not actual forms, they display the information as found on the form for viewing purposes only and will not be accepted if used to request funding or predetermination or to submit a claim request.

The PDF versions of the forms must always be used.

- **NIHB DENT-29 Form**
  To request predetermination, submit a claim or a client reimbursement request, use the NIHB DENT-29 Form PDF

- **Standard Dental Claim Form**
  The Standard Dental Claim Form can also be used for predetermination or to submit a claim request. This form is available from the Canadian Dental Association (CDA).

- **ACDQ Dental Claim and Treatment Plan Form -** *Association des chirurgiens dentistes du Québec*
  To request a predetermination or submit a claim request in Quebec, use the ACDQ Dental Claim and Treatment Plan Form which is available from the Association des chirurgiens dentistes du Québec.

- **Orthodontic Summary Sheet**
  In addition to the NIHB DENT-29 Form, providers should complete the NIHB Orthodontic Summary Sheet PDF when requesting funding for orthodontic treatment.

- **Completion of Active Orthodontic Treatment Form**
  Once the orthodontic treatment is completed, use the NIHB Completion of Active Orthodontic Treatment Form PDF to request final payment.

- **Client Reimbursement Request Form**
  To submit a reimbursement request to the NIHB Program, use the NIHB Client Reimbursement Request Form. PDF
- **NIHB Dental Claim Statement**
  The Non-Insured Health Benefits Dental Claim statement is sent with any claims payment cheques or electronic funds transfer notices. It provides information about each manual or electronic claim processed. View the Sample Dental Claim Statement.

- **Predetermination Confirmation Letter**
  The Predetermination Confirmation Letter is issued to dental providers once predetermination services have been approved. Sample Predetermination Confirmation Letter.
- **Dental and Orthodontic Bulletins**
  The Non-Insured Health Benefits Dental and Orthodontic Bulletins are published as required to inform providers of updates regarding the provision of dental benefits to eligible recipients.

- **Dental Policies**
  The Non-Insured Health Benefits Dental Policies clearly define the clinical criteria and guidelines under which the NIHB Program will fund dental services for eligible registered First Nations and recognized Inuit.

- **Dental Policy Framework** The Non-Insured Health Benefits Dental Policy Framework clearly defines the terms and conditions, policies and benefits under which the NIHB Program will fund dental services for eligible registered First nations and recognized Inuit.

- **Newsletters for Dental Providers**
  The Non-Insured Health Benefits Newsletter for Dental Providers is published quarterly and contains important news and information for dental providers who provide services to NIHB recipients.

- **NIHB Regional Dental Benefit Grid**
  For a complete list of eligible benefits, benefits with frequency limitations and services requiring

predetermination, dental providers must see the current *NIHB Regional Dental Benefit Grid.* To obtain a copy, providers must call the NIHB Toll-Free Inquiry Centre.

- **Orthodontic Benefits - Questions and Answers**
  The Non-Insured Health Benefits Program has developed a series of frequently asked questions for dental providers to provide additional information regarding Orthodontic benefits.

- Questions and Answers - October 2005 Changes to Dental Benefits Requiring Prior Approval and the new Dental Policy Framework

- Questions and Answers - July 2005 Dental Benefits Changes

Drug/Pharmacy

- **Modifications to Pharmacy/MS&E Provider Information form**
  FCH requires certain information about each participating Pharmacy Provider to properly identify and pay the Pharmacy Provider for claims adjudicated by FCH. This form should be accompanied by the signed Pharmacy/MS&E Provider Agreement.
  View the Sample Modifications to Pharmacy/MS&E Information form.

- **Non-Insured Health Benefits Pharmacy Claim Form**
  The Non-Insured Health Benefits Pharmacy Claim Form is used to submit claims request for pharmacy benefit items.
  View the Sample Pharmacy Claim Form.

- **Client Reimbursement Request Form**
  To submit a client reimbursement request to the NIHB Program, use the NIHB Client Reimbursement Request Form. PDF
- **NIHB Pharmacy Claim Statement**
  Twice per month, the Non-Insured Health Benefits Pharmacy Claim Statement is issued to providers, summarizing submitted and entered claims settled during the period.
  View the Sample Pharmacy Claim Statement.

- **Drug Benefit List**
  The Non-Insured Health Benefits Drug Benefit List a listing of the drugs provided as a benefit by the NIHB Program. The list is published once a year in April, with updates generally every three months.

- **Drug Bulletins**
  The Non-Insured Health Benefits Drug Bulletin is published as required to inform providers of updates regarding the provision of drug benefits to eligible recipients.
  The drug bulletins include deletions and additions to the Drug Benefit List, as well as changes in benefit status, the maximum allowable quantities for narcotic combination products, and frequency limits.

- **Drug Use Evaluation Bulletins**
  The Drug Use Evaluation (DUE) bulletin is published as needed to provide information on the findings and recommendations from the Drug Use Evaluation Advisory Committee to the NIHB Program.

- **Newsletters for Pharmacy Providers**
  The Non-Insured Health Benefits Newsletter for Pharmacy Providers is published quarterly and contains important news and information for pharmacy providers who provide services to NIHB recipients.

Eye and Vision Care Benefits

- **NIHB Eye and Vision Producs and Services Prior Approval and Claims Form**
  When requesting funding for vision care benefits to the Non-Insured Health Benefits (NIHB) Program, providers may use the NIHB Eye and Vision Products and Services Prior Approval and Claims Form.

  The form information is available in HTML and Portable Document Format (PDF). The HTML version of the NIHB Eye and Vision Products and Services Prior Approval and Claims Form is not an actual form. It displays the information found on the form for viewing purposes only and will not be accepted if used to request funding.

  Providers wishing to submit a form must use only the PDF version of the NIHB Eye and Vision Products and Services Prior Approval and Claims Form. The form may also be used to submit a reimbursement request.

- **Vision Care Framework**
  The Non-Insured Health Benefits Vision Care Framework clearly defines the benefits and criteria associated with the provision of vision care benefits to NIHB recipients.

Medical Supplies and Equipment

When requesting funding for medical supplies and equipment benefits to the Non-Insured Health Benefits (NIHB) Program, providers may use any of the following forms.

Information on the forms is available in both HTML and Portable Document Format (PDF).

The HTML versions of the forms are not actual forms, they display the information as found on the forms for viewing purposes only and will not be accepted if used to request funding.

Providers wishing to request funding must use the PDF versions of the forms.

- Hearing Aid and Hearing Aid Repair Confirmation Form PDF
- Hearing Aid and Hearing Aid Repair Prior Approval Request Form PDF
- General Medical Supplies and Equipment Prior Approval Form PDF
- Prior Approval Form Orthotics - Custom Footwear Prosthetics - Pressure Garments PDF
- Oxygen and Respiratory Program Prior Approval Form PDF

- **Changing Provider Information**: Medical Supplies and Equipment (MS&E) providers wishing to change any of the provider information communicated upon registration may use the Modifications to Pharmacy/MS&E Provider Information form.
  View the Sample Modifications to Pharmacy/MS&E Information form.

- **Medical Supplies and Equipment Claim Form**
  The Medical Supplies and Equipment Claim Form is used to submit a claim or for a re-submission.
  View the Sample Medical Supplies and Equipment Claim Form.

- **Client Reimbursement Request Form**
  To submit a client reimbursement request to the NIHB Program, use the NIHB Client Reimbursement Request Form. PDF

- **Medical Supplies and Equipment Claim Statement**
  Twice per month, the Medical Supplies and Equipment Claim Statement is issued to providers. It summarizes submitted and entered claims settled during the period. See the Sample Medical Supplies and Equipment Claim Statement.

- **Medical Supplies and Equipment Prior Approval Confirmation Letter**
  The Medical Supplies and Equipment Prior Approval Confirmation Letter is issued by to providers after the approval process for specific MS&E items is complete. The confirmation letter includes applicable dates and prior approval details.
  View the Sample Medical Supplies and Equipment Prior Approval Confirmation Letter.

- **Medical Supplies and Equipment Bulletins**
  The NIHB Medical Supplies and Equipment Bulletins are published as required to inform providers of updates regarding the provision of medical supplies and equipment benefits to eligible recipients.

- **Newsletters for Medical Supplies and Equipment Providers**
  The NIHB Newsletters for Medical Supplies and Equipment Providers are published quarterly and contain important news and information for medical supplies and equipment providers who provide services to NIHB recipients.

Medical Transportation Benefits

- **Medical Transportation Bulletins**
  The Non-Insured Health Benefits Medical Transportation Bulletins are published as required to inform providers of updates regarding the provision of transportation benefits to eligible recipients.

- **Medical Transportation Policy Framework**
  The Non-Insured Health Benefits Medical Transportation Policy Framework outlines the policies and benefits that help recipients access medical services, the types of medical travel eligible for coverage and the benefits provided.

NIHB HEARING AID AND HEARING AID REPAIR CONFIRMATION FORM

PA#: **DATE:**

Section 1: Client Information

Client's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:
Client Address: Client Phone No.: ( )		

Section 2: Prior Approval Invoice Information

Date of Service (DD/MM/YY)	Benefit Code	Description of Benefit	L Ear	R Ear	Prior Approval #	Manufacturer's Invoice or Service Fee	Approved Cost (For NIHB use only)
*Please note this is not an invoice						Total Approved Costs	

Section 3: Manufacturer's Information For Hearing Aid or Hearing Aid Repair

Hearing Aids	Manufacturer	Model	Serial Number	Battery Size	Mfr. Warranty Expiry Date	Date Fitted / Repaired
Left						
Right						

Section 4: Provider Information

Provider Name:	Provider #:
Provider Address:	
Telephone #:	Fax#:

Section 5: Provider Certification

I hereby certify that the information provided above is true and complete, and that the above named client has received and is satisfied with the equipment and instruction and the equipment dispensed and fitting is appropriate to meet the client's needs. I will provide appropriate follow-up during the warranty period.

Date:

Provider Signature Provider Name (please print)

NIHB HEARING AID AND HEARING AID REPAIR PRIOR APPROVAL REQUEST FORM

PA#: **DATE:**

Section 1: Client Information

Client's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:
Client Address: Client Phone No.: ( )		

Section 2: Background Information (Please complete this section for new or replacement hearing aid requests)

Date of most recent audiometric test (copy required for new or replacement hearing aids):
Has the client ever worked in a noisy environment? Yes ☐ No ☐ If **yes**, type of work and how long.
Is the hearing loss the result of an injury? Yes ☐ No ☐ If **yes**, please indicate when and where:
Has the client ever applied with WCB? Yes ☐ No ☐ If **yes**, please indicate claim number:
Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

Section 3: Initial Benefit Requests, Replacements, and Repairs (for new or replacement hearing aids, a copy of the most recent audiometric test must be included for this section to be evaluated. Current hearing aid information must be included for repair and/or replacement requests).

Benefit Code	Description of Benefit	L Ear	R Ear	Unit Cost	Manufacturer Name	Model No. or Name	Date of Fitting	Serial No.

Reason for request:

Section 4: Provider information

Provider Name:	Provider #:
Provider Address:	
Telephone #:	Fax#:
I hereby certify that the above information is true and complete.	
Provider Signature:	Date:

Secion 5: Decision

If not approved, reason for Denial:

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 #:

NIHB PRIOR APPROVAL FORM
ORTHOTICS - CUSTOM FOOTWEAR - PROSTHETICS - PRESSURE GARMENTS

PA#: **DATE:**

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 #:
Item Requested:	

Section 3: Client Health Information

Diagnosis (should be specific to the item being requested):

Explanation of benefit requirement based on clinical assessment by recognized provider and specific details of device to be provided (MUST BE COMPLETED):

Will a follow up assessment be provided? Yes ☐ No ☐

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 (**manufacturing technique, materials to be used, side of body, itemize replacement parts if it is a repair and details of warranty)**	Benefit Code	Qty	Cost	MFR Name (In-house or external?) MFR Item Code Class Type for orthoses/custom footwear

Section 5: Provider Information

Provider Name:	Provider #:
Provider Signature:	Date:
Telephone #:	Fax#:

Section 6: Client Signature

Client: I have received the above mentioned item(s). Signature:	Date:

NIHB OXYGEN AND RESPIRATORY PROGRAM PRIOR APPROVAL FORM

Renewal ☐

Section 1: Patient Information (to be completed by Regional Office)

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

Section 2: Physician Information (to be completed by Physician)

Physician's Name:	License / Billing # :	Telephone #:
		Fax #:
Diagnosis:		Complications: ☐ Cor Pulmonale ☐ Pulmonary Hypertension ☐ Secondary Polycythemia, indicate Hematocrit % _____

Section 3: Client Injury History (to be completed by Physician)

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 ☐

(OXYGEN ONLY)

Section 4: Oxygen Prescription (to be completed by Physician)

	Rest	Exertion	Sleep
Oxygen low rate, 1pm			
Number of hrs / day			

Section 5: Arterial Blood Gas and / or Oxygen Tests (to be completed by Physician) **(OXYGEN ONLY)** Signed and dated oxymetry test must accompany this form if PaO2 is greater than 55mmHg. Future signed and dated oxymetry tests may be requested by FNIHB for assessment. ABG results are required for initial oxygen set up, as well as the three month and one year assessments.

ABGs on room air: Yes ☐ No ☐ If no, specify _____% _____ flowrate.

Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)

Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2	Rest	Exertion	Sleep
					Date:	Date:	Date:

Section 6: Benefit Requested (to be completed by Provider)

Description of Benefit	Benefit Code	Qty	Cost	MFR Name MFR Item Code and Class Type

Section 7: Provider Information (to be completed by Provider)

Provider Name:	Provider #:
Telephone #:	Fax#:

I hereby certify that the information in Sections 5 and 6 is true and complete and that the oxygen equipment and information pertaining to that equipment have been provided to the above named client. The NIHB Program reserves the right to request this form for audit purposes.

Provider Signature:	Date:

Sample Modifications to Pharmacy/Medical Supplies and Equipment (MS&E) Information Form

SECTION 1 - PHARMACY/MS&E PROVIDER INFORMATION

FCH's Pharmacy / MS&E Provider Number 0 | 0 | 0 | 0 | 0 | | | | | | Operating (Store) Name

Street Address

City | Province | Postal Code | Language Preferred ☐ English ☐ Français

Area Code | Telephone Number | Area Code | Fax Number | Contact Name | Title

SECTION 2 - PHARMACY/MS&E PROVIDER MAILING ADDRESS

Complete this section only if cheque payment should NOT be mailed to the Operating Store address indicated in Section 1.

Operating (Store) Name
Street Address
City | Province | Postal Code | Language Preferred ☐ English ☐ Français

Area Code | Telephone Number | Area Code | Fax Number | Contact Name | Title

SECTION 3 - ELECTRONIC FUNDS TRANSFER (EFT) PAYMENT INFORMATION

Complete this section to identify the account to which FCH will direct EFT PAYMENTS and attach a sample/VOID cheque. (This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account. All information will be treated as private and confidential).

❑ **NEW BANKING INFORMATION** ❑ **REPLACE BANKING INFORMATION**

Bank Name | Branch Name

Branch Address | City | Province | Postal Code

ACCOUNT NUMBER Bank | Branch | Account Number

SECTION 4 - PHARMACY/MS&E PROVIDER MANAGEMENT SYSTEM and POINT OF SALE (POS) CLAIMS SUBMISSION

FCH offers a real-time adjudication system, which is compatible with Pharmacy Practice Management Systems, (PPMS) and specially equipped Point of Sale (POS) Devices. **In order to submit claims real-time (POS), you must contact your Pharmacy/MS&E Provider software vendor.** Please provide the following information if you are currently using a PPMS or POS device:

Vendor (Company) Name | Area Code | Telephone Number

Contact Address | City | Province | Postal Code

SAMPLE

Sample Modifications to Pharmacy/Medical Supplies and Equipment Information Form

First Canadian Health (FCH) requires certain information about each participating Pharmacy/MS&E Provider to properly identify and pay the Pharmacy/MS&E Provider for claims adjudicated by FCH. Please complete this form and return it with the signed Pharmacy/MS&E Provider Agreement. Cheque payment will be mailed to the Operating Store address unless Section 2 or 3 of the form are completed.

Section 1 - Pharmacy/Medical Supplies and Equipment Provider Information:

First Canadian Health (FCH) Pharmacy / Medical Supplies and Equipment Provider Number

Operating (Store) Name
Street Address
City
Province
Postal Code
Language Preferred: English/French

Telephone Number
Fax Number
Contact Name
Title

Section 2 - Pharmacy/Medical Supplies and Equipment Provider Mailing Address

Note: This section is completed only if cheque payment should **NOT** be mailed to the Operating Store address indicated in Section 1 of the form.

Operating (Store) Name
Street Address
City
Province
Postal Code
Language Preferred: English/French
Telephone Number
Fax Number
Contact Name
Title

Section 3 - Electronic Funds Transfer (EFT) Payment Information:

This section is completed to identify the account to which FCH will direct EFT PAYMENTS and attach a sample/VOID cheque. (This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account. All information will be treated as private and confidential).

New Banking Information/Replace Banking Information
Bank Name
Branch Name
Branch Address
City
Province
Post Code

Account Number Information:
Bank
Branch
Account Number

Section 4 - Pharmacy/Medical Supplies and Equipment Provider Management System and Point of Sale (POS) Claims Submission:

FCH offers a real-time adjudication system, which is compatible with Pharmacy Practice Management Systems (PPMS) and specially equipped Point of Sale (POS) Devices. **In order to submit claims real-time (POS), you must contact your Pharmacy/MS&E Provider software vendor.** Please provide the following information if you are currently using a PPMS or POS device:

Vendor (Company) Name;
Area Code;
Telephone Number;
Contact Address;
City;
Province; and
Postal Code.

Sample Medical Supplies and Equipment Claim Form

Health Canada / Santé Canada

MEDICAL SUPPLIES AND EQUIPMENT CLAIM FORM
NON-INSURED HEALTH BENEFITS FOR ELIGIBLE FIRST NATIONS AND INUIT

FORMULAIRE DE DEMANDE DE PAIEMENT POUR ÉQUIPEMENT MÉDICAL ET FOURNITURES MÉDICALES
SERVICES DE SANTÉ NON ASSURÉS POUR LES PREMIÈRES NATIONS ET LES INUITS ADMISSIBLES

CLIENT INFORMATION / RENSEIGNEMENTS SUR LE BÉNÉFICIAIRE

OR / OU

CLAIM INFORMATION / RENSEIGNEMENTS SUR LA DEMANDE

1.
2.
3.

Total

1.
2.
3.

OR / OU

PART 1 FIRST CANADIAN HEALTH
NHB CLAIMS DEPT
3080 YONGE STREET, STE. 3002
TORONTO, ON M4N 3N1

COPIE 1 FIRST CANADIAN HEALTH
DEPT DES DEMANDES DE PAIEMENT DES SSNA
3080, RUE YONGE, PIÈCE 3002
TORONTO, ON M4N 3N1

PART / COPIE 2 PROVIDER COPY (PLEASE RETAIN FOR YOUR FILE)
EXEMPLAIRE DU FOURNISSEUR (À CONSERVER DANS VOS DOSSIERS)

SAMPLE

Sample Medical Supplies and Equipment Claim Form

Client Surname
The surname under which the client is registered as an eligible First Nations or recognized Inuit client.

Client Given Name
The given name under which the client is registered as an eligible First Nations or recognized Inuit client. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Client Date Of Birth (dd/mm/yyyy)
The client's full birth date in day-month--year format (for example, 13/05/1992 represents 13 May 1992). Partial birth dates are not acceptable.

Code: Client Identification No.
A unique number used to identify a client who is eligible to receive benefits under the NIHB Program. This number may be one of:

- 9 or 10-digit number issued to eligible First Nations clients by the Department of Indian and Northern Affairs Canada (**INAC**);
- 3-digit **band number** , immediately followed by the 4 or 5-digit **family number** identifying the family unit within the eligible First Nations client's band;
- An alpha prefix followed by an 8-digit number issued to certain eligible First Nations and recognized Inuit clients by First Nations and Inuit Health Branch (**FNIHB**); or
- **Health care number** issued to recognized Inuit clients by the Government of the Northwest Territories and the Government of Nunavut.

Band No.
A 3-digit number (for example, 002, 311) identifying the band to which an eligible First Nations client belongs. The band number, when submitted in combination with the client's family number, is an acceptable alternative to the client identification number for an eligible First Nations client.

Family No.
A 4 or 5-digit number (for example, 1041, 04120) identifying the family unit within the band to which an eligible First Nations client belongs. The family number, when submitted in concert with the client's band number, is an acceptable alternative to the client identification number for an eligible First Nations client. If the family number on the eligible First Nations client's registration card has fewer than 5 digits, please insert the appropriate number of zeros in front of the number.

Date Of Service (dd/mm/yyyy)
The date on which service was provided to the client, in day-month- year format (for example, 13/05/1992 represents 13 May 1992).

DIN/Item Code
The Drug Identification Number (DIN) or item code.

Quantity
The quantity (number of units) of the item dispensed.

Prescription No.
The prescription number assigned by your pharmacy for the item dispensed.

Drug/Item Cost
The total ingredient or acquisition cost for all units of the drug or item dispensed.

Dispensing Fee
The dispensing fee for the item dispensed. Leave blank if not applicable.

Markup
The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.

Third-Party Share
The dollar amount of any portion of the claim which is billable to a provincial or territorial program or other third party. Leave blank if not applicable.

Amount Claimed
The sum of the drug/item cost, dispensing fee, and mark-up for the item, less any third-party share.

Days Supply
Estimate of number of days of treatment contained in the prescription.

Total
The total dollar amount claimed for all items (up to 3) listed on the claim form.

Prescriber
The prescriber number as entered by the provider on the claim submission must be the same as required by the provincial/territorial pharmacare program . Claims for repair, labour, and replacement parts must be submitted with '999Repair' in the prescriber field or they will be rejected on the NIHB Pharmacy Claim Statement with an **R14** error (Insufficient Benefit Information to Adjudicate Claim).

- British Columbia Physician License Number
- Alberta Physician License Number
- Saskatchewan Physician's Provincial Billing Number
- Manitoba Physician License Number
- Ontario Physician License Number
- Quebec Physician License Number
- New Brunswick Physician's Provincial Billing Number
- Nova Scotia Physician License Number
- Prince Edward Island Physician License Number
- Newfoundland Physician License Number
- Yukon Physician's Territorial Billing Number
- Northwest Territories Physician License Number
- Nunavut Physician License Number

Prior Approval No.
An authorization number, which must be issued by FNIHB before the provider dispenses certain drugs, medical supplies and most medical equipment (Health Canada NIHB Drug Exception Centre for drugs and the FNIHB Regional Office for Medical Supplies and Equipment).

Pharmacy Name
The name of the pharmacy submitting the claim, may be formatted as determined by the pharmacy.

Pharmacy Address
The address of the pharmacy submitting the claim, may be formatted as determined by the pharmacy.

Pharmacy Number
The number assigned to the pharmacy upon registration as an NIHB provider.

Parent Information (Required For Infants Less Than One Year Of Age)

Parent's Surname
The surname under which the parent is registered as an eligible First Nations or recognized Inuit client.

Parent's Given Names
The given names under which the parent is registered as an eligible First Nations or recognized Inuit client. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Parent's Date Of Birth (dd/mm/yyyy)
The parent's full birth date in day-month--year format (for example, 13/05/1956 represents 13 May 1956). Partial birth dates are not acceptable.

Parent's Client Identification No.
The number under which the parent is identified as an eligible First Nations or recognized Inuit client. This number may be one of:

- 9 or 10-digit number issued to eligible First Nations clients by the Department of Indian and Northern Affairs Canada (**INAC**);
- 3-digit **band number** , immediately followed by the 4 or 5-digit **family number** identifying the family unit within the eligible First Nations client's band;
- An alpha prefix followed by an 8-digit number issued to certain eligible First Nations and recognized Inuit clients by FNIHB, or
- **Health care number** issued to recognized Inuit clients by the Government of the Northwest Territories and the Government of Nunavut.

Parent's Band No.
A 3-digit number (for example, 002, 311) identifying the band to which an eligible First Nations client's parent belongs. The band number, when submitted in combination with the family number, is an acceptable alternative to the client identification number for an eligible First Nations client.

Parent's Family No.
A 4 or 5-digit number (for example, 1041, 04120) identifying the family unit, within the band, to which an eligible First Nations client's parent belongs. The family number, when submitted in combination with the band number, is an acceptable alternative to the client identification number for an eligible First Nations client. If the family number on the eligible First Nations client's registration card has fewer than 5 digits, please insert the appropriate number of zeroes in front of the number.

NIHB Client Reimbursement Request Form

First Nations and Inuit Health Branch
Non-Insured Health Benefits (NIHB) Program

Part 1 - Recipient Information

Surname:		First and Middle Name:
Recipient Identification Number <**OR**> Band and Family Numbers:		Date of Birth:
Mailing Address:		City:
Province:	Postal Code:	Telephone number: ( ) -

Part 2 - Information on Parent or Guardian or Person having a legally recognized authority to act on behalf of a child under 18 or an incapacitated (mentally incompetent) person

Please fill out if recipient is a child under the age of 18 years or an incapacitated (mentally incompetent) person and you are their parent or guardian or person having a legally recognized authority to act on their behalf. If recipient is under one year of age and not registered, please provide parent's information

Surname:	First Name:
Identification Number <**OR**> Band and Family Numbers:	Date of Birth:
Relationship to recipient:	Telephone number: ( ) -

Part 3 - Other Plans

Are these expenses eligible for funding under another health plan or program? Yes ☐ No ☐ **If yes, please provide:**
your Claim Number: and name of Insurance Company:

Part 4 - Details of Claim

Attach the original receipts, prescription and any other relevant documentation. If an expense has been submitted under another plan, attach the receipts and statement of benefits from that plan. For dental reimbursements, please use a Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, Computer Generated Form with the NIHB Reimbursement Form attached, or NIHB Dent-29 Form.

Benefit Category Drugs, Dental, Vision, Medical Transportation, Medical Supplies and Equipment, Short-term Crisis Intervention Mental Health Counselling	**Date of Service** (Day/Month/Year)	**Cost**
	TOTAL AMOUNT CLAIMED:	

Please indicate Payee name and address, if different from Part 1 or Part 2 above:

Name:	Mailing Address:	
City:	Province:	Postal Code:

Part 5 - Recipient, Parent/Guardian Authorization

I authorize Health Canada, its agents/contractors, the claims administrators/processors or others who provide health care benefits, items or services according to the NIHB Program to use and disclose information about me that is collected by this claim and in my claims history for the administration of this claim. I declare that all the information provided by me in completing this form is true and accurate and does not contain a claim for any benefit or service previously paid for by Health Canada or by any other plan.

Signature:	**Date:**

Instructions on where to mail your request for reimbursement and what information to provide is listed on the reverse side of this form.

For NIHB Use Only:

WHERE TO MAIL YOUR REQUEST FOR REIMBURSEMENT OF NON-INSURED HEALTH BENEFITS

Pacific Region
First Nations and Inuit Health Branch
Federal Building
ATTN: NIHB Unit
757 West Hastings Street, Suite 540
Vancouver, British Columbia V6C 3E6

Manitoba Region
First Nations and Inuit Health Branch
Stanley Knowles Federal Building
ATTN: NIHB Unit
391 York Avenue, Suite 300
Winnipeg, Manitoba R3C 4W1

Alberta Region
First Nations and Inuit Health Branch
Canada Place
ATTN: NIHB Unit
9700 Jasper Avenue, Suite 730
Edmonton, Alberta T5J 4C3

Québec Region
First Nations and Inuit Health Branch
Complexe Guy-Favreau
ATTN: NIHB Unit
200 West René Lévesque Boulevard
East Tower, Suite 216
Montréal (Québec) H2Z 1X4

Ontario Region
First Nations and Inuit Health Branch
Emerald Plaza
ATTN: NIHB Unit
1547 Merivale Road, 3rd floor
Postal Locator 6103A
Nepean, Ontario K1A OL3

Atlantic Region
First Nations and Inuit Health Branch
ATTN: NIHB Unit
1505 Barrington Street
Suite 1525, 15th Floor, Maritime Centre
Halifax, Nova Scotia B3J 3Y6

Northern Secretariat, Yukon
First Nations and Inuit Health Branch
Elijah Smith Building
ATTN: NIHB Unit
300 Main Street, Suite 100
Whitehorse, Yukon Y1A 2B5

Northern Secretariat (NWT and Nunavut)
First Nations and Inuit Health Branch
ATTN: NIHB Unit
60 Queen Street, 14th floor
Postal Locator 3914A
Ottawa, Ontario K1A 0K9

Saskatchewan Region
First Nations and Inuit Health Branch
Chateau Tower
ATTN: NIHB Unit
1920 Broad Street, 18th floor
Regina, Saskatchewan S4P 3V2

INFORMATION WHICH YOU NEED TO INCLUDE WITH YOUR COMPLETED REQUEST FOR REIMBURSEMENT FORM

All requests for reimbursement of eligible benefits must be made within one year from the date of service.

Dental Services	Attach a completed Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, Computer Generated Form, or NIHB Dent-29 Form. If a portion of the service was paid by a third party, include the Explanation of Benefits.
Prescription Drugs	The official prescription receipt from the pharmacy which has the prescription number, name of the doctor, DIN code, quantity, amount paid and date of service, *or* attach the Explanation of Benefits Statement if a portion was paid by a third party.
Medical Supplies and Medical Equipment	A copy of your doctor's prescription. Include medical justification explaining the need for the benefit/item, original dated invoice with manufacturer name and product number which includes a detailed quotation and fabrication method (if applicable) from the service provider.
Vision Care	A copy of the prescription from your optometrist or opthalmologist, detailed original receipt with costs separated for frames, lenses, eye exam and dispensing fees (if applicable).
Medical Transportation	Prior approval is required from your nearest First Nations and Inuit Health Branch Office or delegate First Nations authority. You will need to include a confirmation slip from your doctor or approved service provider indicating that you attended an appointment or obtained services.
Short-term Crisis Intervention Mental Health Counselling	Please contact your nearest First Nations and Inuit Branch Office for reimbursement details.

Medical Supplies and Equipment (MS&E) Claim Statement

1234567890123456789012345678901234567890123456789012345678901234567890123456789

NHB M.S.& E CLAIM STATEMENT

PROVIDER NO: XXX-9-XXX
XXXXXXXXXXXX-30-XXXXXXXXXXXX

DATE: DD-MM-YYYY
PAGE:9999

DATE OF SERVICE	RX NO.	CLIENT ID NO	SURNAME	GIVEN NAME	D.O.B	BAND FAMILY	DOC/INV NO
PRESCRIBER	APPROVAL NO.	DIN/ITEM CODE	QTY DRUG/ITEM COST	DISP. FEE MARK UP	3RD PARTY	AMT CLAIMED	NET AMT
DD-MM-YYYY XXXXX-10-XXXXXX XXX XXX XXX	XX-9-XX XXX-10-XXX XXX	XXX-10-XXX XX-8-XXX	XXXXXXXX-20-XXXXXXXX X-5-X 9999.99	XXXXXXXX-20-XXXXXXXX 9999.99 9999.99	DD-MM-YYYY 9999.99	XXX XXXXX 99999.99	XXX-10-XXX 99999.99-
DD-MM-YYYY XXXXX-10-XXXXXX XXX XXX XXX	XX-9-XX XXX-10-XXX XXX	XXX-10-XXX XX-8-XXX	XXXXXXXX-20-XXXXXXXX X-5-X 9999.99	XXXXXXXX-20-XXXXXXXX 9999.99 9999.99	DD-MM-YYYY 9999.99	XXX XXXXX 99999.99	XXX-10-XXX 99999.99-
DD-MM-YYYY XXXXX-10-XXXXXX XXX XXX XXX	XX-9-XX XXX-10-XXX XXX	XXX-10-XXX XX-8-XXX	XXXXXXXX-20-XXXXXXXX X-5-X 9999.99	XXXXXXXX-20-XXXXXXXX 9999.99	DD-MM-YYYY 9999.99	XXX XXXXX 99999.99	XXX-10-XXX 99999.99-
DD-MM-YYYY XXXXX-10-XXXXXX XXX XXX XXX	XX-9-XX XXX-10-XXX XXX	XXX-10-XXX XX-8-XXX	XXXXXXXX-20-XXXXXXXX X-5-X 9999.99	XXXXXXXX-20-XXXXXXXX 9999.99	DD-MM-YYYY 9999.99	XXX XXXXX 99999.99	XXX-10-XXX 99999.99-
DD-MM-YYYY XXXXX-10-XXXXXX XXX XXX XXX	XX-9-XX XXX-10-XXX XXX	XXX-10-XXX XX-8-XXX	XXXXXXXX-20-XXXXXXXX X-5-X 9999.99	XXXXXXXX-20-XXXXXXXX 9999.99	DD-MM-YYYY 9999.99	XXX XXXXX 99999.99	XXX-10-XXX 99999.99-

PAID BY: CHEQUE 00000000
OR DIRECT DEPOSIT

**TOTAL NET AMOUNT: 00000.00-
CREDIT BALANCE FORWARD: 99999.99-
CURRENT CREDIT BALANCE: 99999.99-

GRAND TOTAL PAID: 99999.99-

SAMPLE

Medical Supplies and Equipment Claim Statement

Date Of Service
Claims are presented on the statement in order of date of service (oldest date first).

Prescription No.
Claims with the same date of service are presented in order of prescription number.

Client Information
The information includes Client ID No., Surname, Given Names, and Date of Birth. The client information on the statement is based on the NIHB client list. Warning messages are shown for claimants who have been accepted as NIHB clients on a temporary basis only (unregistered infant) and for claims submitted on paper claim forms. Where client-identification information corrections have been made, a W14 message is indicated. Please use the corrected client identification information on future claims to expedite client verification.

Band No. and Family No.
These fields refer to the claimant's band number and family number (sometimes called a treaty number).

Doc/Inv. No
This field refers to the NIHB Health Information Claims Processing System (HICPS) system-number, generated for each claim.

Prescriber No.
This field refers to the prescriber number as entered by the provider on the claim submission, which must be the same as required by the provincial/ territorial pharmacare program.

- British Columbia Physician License Number
- Alberta Physician License Number
- Saskatchewan Physician's Provincial Billing Number
- Manitoba Physician License Number
- Ontario Physician License Number
- Quebec Physician License Number
- New Brunswick Physician's Provincial Billing Number
- Nova Scotia Physician License Number
- Prince Edward Island Physician License Number
- Newfoundland Physician License Number
- Yukon Physician's Territorial Billing Number
- Northwest Territories Physician License Number
- Nunavut Physician License Number

Approval No.
This field is valued only for those items for which an FNIHB prior approval was provided.

DIN/Item Code
This field indicates the Drug Identification Number (DIN) or item code.

Quantity
This field indicates the quantity (number of units) of the item dispensed.

Drug/Item Cost
The total ingredient or acquisition cost for all units of the drug or item dispensed.

Dispensing Fee
The dispensing fee for the item dispensed.

Mark-Up
The dollar amount of any mark-up for the item, based on the percentage.

Third Party
The dollar amount of any portion of the claim billable to a provincial or territorial program or other third party.

Amount Claimed
The sum of the drug-item cost, dispensing fee and mark-up for the item.

Net Amount
This field shows the net payable amount.

Grand Total Paid
This field shows the grand total paid on the final page of the MS&E Claim Statement.

List Terminology:

Field Name:
The name of the field, corresponds to the field on the claim form.

Length:
The field length specification for claims submitted on computer printouts or diskettes.

Description:
A brief description of the data element.

Fields marked with an asterisk (*) are mandatory.

Field Name: *Client Surname
Length : 30
Description : The surname under which the client is registered.

Field Name: **Client Given Name
Length : 30
Description : The given name(s) under which the client is registered. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Field Name : ***Client Date Of Birth (DD/MM/YYYY)**
Length : 8
Description : The full birth date in dd/mm/yyyy format (For example, 13/05/1992 represents 13 May 1992). Partial birth dates are not acceptable.

Field Name : *** Address /Apt/ City /**
Length : Prov./Postal Code
Description : N/A
The current and exact address of the client.

Field Name : ***Client Identification No.**
Length : 10
Description : A unique number used to identify a client who is eligible to receive benefits under the NIHB Program. This number may be one of:

- a 9 or 10-digit number issued to eligible First Nations clients by Indian and Northern Affairs Canada (INAC),
- an alpha prefix followed by an 8-digit number issued to certain eligible First Nations and recognized Inuit clients by FNIHB, or
- an alpha prefix followed by a 7-digit health care number issued to recognized Inuit by the Government of the Northwest Territories or the Government of Nunavut.

Field Name : ***Band No.** ***(Not Applicable To Inuit Clients)***
Length : 3
Description : A 3-digit number (For example,, 002, 311) identifying the band to which the client belongs. The band number, if submitted in combination with the client's family number, is an acceptable alternative to the client identification number for an eligible First Nations client.

Field Name : ***Family No.** ***(Not Applicable To Inuit Clients)***
Length : 5
Description : A 4 or 5-digit number (For example, 1041, 04120) identifying the family unit, within the band, to which a client belongs. The family number, if submitted in combination with the client's band number, is an acceptable alternative to the client identification number. If the family number has fewer than 5 digits, please insert the appropriate number of zeros in front of the number *(* For example, 125 becomes 00125 *).*

Data Element Descriptions -- Claim Information for Each Prescribed Item

Field Name : **Date Of Service (DD/MM/YYYY))**
Length : 10
Description : The date on which service was provided to the client, in dd/mm/yyyy format (for example, 13/05/1992 represents 13 May 1992).

Field Name : ***DIN/Item Code**
Length : 8
Description : The item code.

Field Name : ***Quantity**
Length : 5
Description: The quantity (number of units) of the item dispensed.

Field Name : ***Prescription No.**
Length : 9
Description : The prescription number assigned by the MS&E provider for the item dispensed.

Field Name : ***Item Cost**
Length : 6
Description : The total acquisition cost for all units of the item dispensed.

Field Name : **Dispensing Fee**
Length : 6
Description : The dispensing fee for the item. Leave blank if not applicable.

Field Name : **Markup**
Length: 6
Description: The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.

Field Name : ***Third-Party Share**
Length : 6
Description : The dollar amount of any portion of the claim which is billable to a provincial or territorial program or other third party. Leave blank if not applicable.

Field Name : ***Amount Claimed**
Length : 6
Description : The sum of the item cost, dispensing fee, and mark-up for the item, less any third-party share.

Field Name : **Days Supply**
Length : 3
Description : Estimate of the number of days of treatment contained in the prescription.

Field Name : **Total**
Length : 6
Description : The total dollar amount claimed for all items (up to 3) listed on the claim form.

Field Name : ***Prescriber**
Length : 10
Description : The prescriber number as entered by the provider on the claim submission must be the same as required by the provincial/territorial pharmacare program. Claims for repair labour and replacement parts must be submitted with '999Repair' in the prescriber field, or they will be rejected on the NIHB MS&E Claim Statement with an **R14** error (Insufficient Benefit Information to Adjudicate Claim).

- British Columbia Physician License Number
- Alberta Physician License Number
- Saskatchewan Physician's Provincial Billing Number
- Manitoba Physician License Number
- Ontario Physician License Number
- Quebec Physician License Number
- New Brunswick Physician's Provincial Billing Number
- Nova Scotia Physician License Number
- Prince Edward Island Physician License Number
- Newfoundland Physician License Number
- Yukon Physician's Territorial Billing Number
- Northwest Territories Physician License Number
- Nunavut Physician License Number

Data Element Descriptions -- Medical Supplies and Equipment Provider Information

Field Name : ***Prior Approval No.**
Length : 8
Description : An authorization number, which must be issued by FNIHB before the provider dispenses certain drugs, medical supplies and most medical equipment.

Field Name: *Provider/Supplier Name
Length : N/A
Description : The name of the provider/supplier submitting the claim. May be formatted as determined by the provider/supplier.

Field Name: *Provider/Supplier Address
Length : N/A
Description : The address of the provider/supplier submitting the claim. May be formatted as determined by the provider/supplier.

Field Name: *Provider/Supplier Number
Length : 10
Description : The number assigned to the provider/supplier upon registration as an NIHB provider with FCH.

Parent Information (required for infants under one year of age)

An infant under one year of age who does not yet have a client identification number may receive benefits if one of the infant's parents can be verified as an eligible client. In such a case, the infant's surname, all given names, and the date of birth must be entered in the appropriate fields in the Client Information section of the claim (**Note** : these claims may only be submitted using the Non-Insured Health Benefits Medical Supplies and Equipment Claim Form), and this information about the parent must be provided:

Field Name: *Parent's Surname
Length: 30
Description: The surname under which the parent is registered.

Field Name: *Parent's Given Names
Length: 30
Description: The given names under which the parent is registered. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Field Name: *Parent's Date Of Birth (DD/MM/YYYY))
Length: 8
Description: The parent's full birth date in day-month-century-year format (for example, 13/05/1956 represents 13 May 1956). Partial birth dates are not acceptable.

Field Name: * Address /Apt/ City / Prov./Postal Code
Length: N/A
Description: The current and exact address of the parent.

Field Name: *Parent's Client Identification No.
Length: 10
Description: The unique number under which the parent is registered. This number may be one of:

- 9 or 10-digit number issued by Indian and Northern Affairs Canada (INAC),
- 3-digit band number, immediately followed by the 4 or 5-digit family number identifying the family unit within the client's band,
- An alpha prefix followed by 8 digit number issued to certain eligible clients by FNIHB, or
- A health care number issued by the Government of the Northwest Territories or Nunavut.

Field Name: *Parent's Band No. *(N ot Applicable To Inuit Clients)*
Length: 3
Description: A 3-digit number (For example, 002, 311) identifying the band to which the infant's parent belongs. The band number, if submitted in combination with the family number, is an acceptable alternative to the INAC client identification number.

Field Name: Parent's Family No. *(N ot Applicable To Inuit Clients)*
Length: 5
Description: A 4 or 5-digit number (For example, 1041, 04120) identifying the family unit, within the band, to which the infant's parent belongs. The family number, if submitted in combination with the band number, is an acceptable alternative to the INAC client identification number. If the family number has fewer than 5 digits, please insert the appropriate number of zeros in front of the number.

Sample Medical Supplies and Equipment Prior Approval Confirmation Letter

Medical Supplies and Equipment Prior Approval Confirmation Letter

Health Canada Protected
From Address
Approval Date (Prior Approval Date)
To Address (Provider)
Re: Confirmation of Prior Approval
Client # (Blank If Infant)
Surname
Given Name
Band Number
Family Number
Date Of Birth dd/mm/yyyy format
Parent Number (For Infants Only)

This is to confirm that prior approval number has been issued for the provision of the following item(s), except where indicated:

Item Code
Item Name
Quantity
Fee
Refill #
Markup
Third Party
Total Approved
Not Approved
Start Date
Expiry Date
Min Qty Per Claim
General Comments

Note: Please quote Prior Approval Number on your claim submission.

FROM:

XXXXXXXXXXXXXXXXXXX-50-XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX HC PROTECTED
XXXXXXXXXXXXXXXXXX-50-XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX-50-XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX-50-XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX-35-XXXXXXXXXXXX
XXXXXXXXXXXXXXX-35-XXXXXXXXXXXXX
XXXXXXXXXXXXXXX-35-XXXXXXXXXXXXX, ON A9A 9A9

APPROVAL DATE:

DD/MM/CCYY (PA DATE)

TO:

XXXXXXXXXXXXX-30-XXXXXXXXXX
XXXXXXXXXXXX-35-XXXXXXXXXXXXXXXX
XXXXXXXXXXX-35-XXXXXXXXXXXXXXXXXX
XXXXXXXXXX-35-XXXXXXXXXXXXXXXXXX
XXXXXXXXXX-35-XXXXXXXXXXXXXXXXXX, ON
A9A 9A9

DEAR SIR / MADAM

RE: CONFIRMATION OF PRIOR APPROVAL

CLIENT # : XXXXXXXXXX (BLANK IF INFANT)
SURNAME : XXXXXXXX-30-XXXXXXXXXXXXXXXXX
GIVEN NAME : XXXXXXX-30-XXXXXXXXXXXXXXXXXXX
BAND # : -3-
FAMILY # : X-5-X
DATE OF BIRTH : DD/MM/YYYY
PARENT # : XXX-10-XXX (FOR INFANTS ONLY)

THIS IS TO CONFIRM THAT PRIOR APPROVAL NUMBER XX-8-XXX HAS BEEN ISSUED FOR THE PROVISION OF THE FOLLOWING ITEM(S), EXCEPT WHERE INDICATED:

ITEM CODE	XXXXXXXX	XXXXXXXX	XXXXXXXX
ITEM NAME	XXXXX-15-XXXXXX	XXXXXXXXXXXXX	XXXXXXXXXXXXX
QUANTITY	XXXXX	XXXXX	XXXXX
UNIT COST	9,999.99	9,999.99	9,999.99
FEE	9,999.99	9,999.99	9,999.99
REFILL #	99	99	99
MARKUP	9,999.99	9,999.99	9,999.99
THIRD PARTY	9,999.99	9,999.99	9,999.99
TOTAL APPROVED	9,999.99	9,999.99	NOT APPROVED
START DATE	01/01/1998	01/01/1998	01/01/1998
EXPIRY DATE	01/01/1998	01/01/1998	01/01/1998
MIN QTY PER CLAIM	XXXXX	XXXXX	XXXXX

GENERAL COMMENTS

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SAMPLE