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.