NIHB EYE AND VISION PRODUCTS AND SERVICES PRIOR APPROVAL AND CLAIMS FORM

Health Canada Protected

[ ] For Prior Approval
[ ] For Claim

Provider to Complete

PART 1 - CLIENT INFORMATION

_____
SURNAME GIVEN NAME(S)

_____
ADDRESS APT CITY

_____(_____) _____
PROVINCE POSTAL CODE AREA CODE TELEPHONE

_____D.O.B._____/_____/_____
CLIENT ID NO. DD MM YY

_____
BAND NO. FAMILY NO.

PART 2 - CLIENT INJURY HISTORY

Is request due to an injury? Yes ☐ No ☐

If yes, where did the injury occur:

Home ☐ Work ☐ Other ☐

If other, please specify: _____

Date of injury: _____/_____/_____
DD MM YY

Are these expenses eligible under another plan or program? Yes ☐ No ☐

If yes, please specify: _____

Claim No.: _____

PART 3 - PROVIDER INFORMATION

(Please use office stamp if available)

_____
PROVIDER NO.

_(_____)_____
AREA CODE TELEPHONE

_____
PROVIDER SIGNATURE

PART 4 - OPTICAL INFORMATION/PRESCRIPTION

Oculo-visual Measure	Sphere	Cyl	Axis	Prism	Base	Add
Right						
Left						

DIAGNOSIS & OTHER RELEVANT INFORMATION:

BENEFITS REQUESTED: (please complete information as is applicable in the region where benefit is accessed, for each product or service)

Benefit Description, Items	Initial Request (√)	Replacement (√)	Acquisition cost	Mark-up in $	Total Cost	MFR Product Name	Product Number	Warranty Yes(√)	Warranty No(√)
EYE AND VISION EXAMS (ONLY in regions where applicable)									
Eye/vision exam, general (full, major, routine)									
DISPENSING FEES (ONLY in regions where applicable)									
Fame dispensing fee, existing frame									
Frame dispensing fee, new									
Laboratory fee									
Lenses dispensing fee, bifocal									
Lenses dispensing fee, unifocal									
Delivery (remote areas, mailing & registration)									
FRAMES & FRAME REPAIRS									
Regular									
Frame repairs, major									
Frame repairs, minor									
LENSES, OPTHALMIC									
Aspheric lens, left									
Aspheric lens, right									
Bifocal lens, left									
Bifocal lens, right									
High index, left									
High index, right									
Unifocal (Crown glass or plastic CR-39)									
Other									

PART 5 – CLIENT SIGNATURE

Client: I have received the above item(s) or service(s).

_____/_____/_____
SIGNATURE OF CLIENT, PARENT OR GUARDIAN **Relationship to Patient if Guardian** **Date** **DD** **MM** **YY**

PART 6 – FOR NIHB OFFICE USE ONLY

PA Approval Number _____ **Date** _____ **Authorizing Officer**_____