NIHB Client Reimbursement Request Form

Documents required by the NIHB Program to reimburse costs related to health services can be found on the next page of this form. Please note that all NIHB policies and requirements for coverage apply. **Note: All requests for reimbursement of eligible benefits must be made within one year from the date of service.**

It is important to submit ALL related documents or there will be a delay in processing your claim. Please keep copies for your files.

Part 1 – Client Information (client receiving the service)

Surname:		First and Middle Names:
Address:	Apt.:	Postal Code:
City:	Province/Territory:	Telephone number: ( ) -
Identification Number:		Date of Birth: / / (YYYY/MM/DD)
Are you covered for any of these expenses under any other health plan(s)/program(s)? **No** ❑ **Yes** ❑ **If yes**, please attach a copy of a detailed statement or explanation of benefits form from all other plan(s)/program(s).		

Part 2 – Parent, Guardian or Person to whom payment should be made
Please provide the name and address of the person to whom payment should be made if different from client receiving the service. If client is under one year of age and not registered, please provide parent or guardian information. The person must also be over the provincial/territorial legal age.

Surname:		First and Middle Names:
Address:	Apt.:	Postal Code:
City:	Province/Territory:	Telephone number: ( ) -
Identification Number (if applicable):		Date of Birth: / / (YYYY/MM/DD)
Relationship to Treated Client:		

Part 3 – Details of Claim
Instructions on what information is needed to be included with the completed client reimbursement form are listed on the next page. Fill in the total of **all** receipts for each category.

List Benefit Items Requested: (Prescription drugs, Medical Supplies & Equipment, Vision and Eye Care, Medical Transportation or Dental/Orthodontic Benefits)	**Cost**
TOTAL AMOUNT CLAIMED:	

Part 4 – Authorization and Signature

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to Health Canada, it's agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be 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(s)/program(s) that is noted in the statement or explanation of benefits.

Client, Parent, Guardian or Person having a legally recognized authority **Date:** / / (YYYY/MM/DD)

Print Name: **Signature:**

Privacy statement
Health Canada also requires your authorization in order to collect information from your medical provider for services provided to you and paid for by the Non-Insured Health Benefits Program. The NIHB Program is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the NIHB Program collects, uses, discloses and retains your personal information in accordance with the applicable federal privacy laws and policies. Further details of the NIHB Privacy Code can be found on the Health Canada website: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php.

INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

FOR ALL BENEFITS:

- Original receipt(s) for proof of payment. Credit card/Debit (Interac) slips are not acceptable forms for proof of payment.
- Sign and complete all applicable parts of this NIHB Client Reimbursement Request Form. Forms that are not signed will be returned to the client for signature**. Please see exceptions to the Dental /Orthodontic and Medical Transportation Benefits below.**
- If applicable, submit your detailed statement or explanation of benefits form from all other health plan(s)/program(s). Note: Original receipts are not required when submitting the detailed statement or explanation of benefits form as the primary insurer requires them. In such cases, a copy of the original receipt is acceptable.

Prescription Drugs

- No additional information other than what is listed above is required.

In addition to the items listed above, please submit the specific requirements for the benefits listed below:

Medical Supplies and Equipment, Vision & Eye Care

- A copy of your prescription.

Dental or Orthodontic Services (**Please note:** When submitting for reimbursement specifically for **Dental or Orthodontic Services only**, you may use the NIHB Client Reimbursement Request Form **OR** a Dent-29 Form).

- A completed claim form provided by the dental or orthodontic service provider. Only need **one** of the following:
  - Association des Chirurgiens Dentistes du Québec Dental Claim and Treatment Plan Form
  - Standard Dental Claim Form
  - Canadian Association of Orthodontics Information Form

Medical Transportation (**Please note:** When submitting for reimbursement specifically for medical transportation **only**, you may use the NIHB Client Reimbursement Request Form **OR** a regional specific medical transportation form provided by the Health Canada regional office).

- Proof of your medical appointment attendance.

MAILING INSTRUCTIONS

For all reimbursements (other than Orthodontics), please mail your completed form(s) and receipt(s) to the Health Canada Regional Office where service was provided.

BC Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
757 West Hastings Street, Suite 540
Vancouver, British Columbia V6C 3E6
Telephone (toll-free): 1-800-317-7878
Dental (toll-free): 1-888-321-5003

Alberta Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
9700 Jasper Avenue, Suite 730
Edmonton, Alberta T5J 4C3
Telephone (toll-free): 1-800-232-7301
Dental (toll-free): 1-888-495-2516

Saskatchewan Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
2045 Broad Street, South Broad Plaza, 1st Floor
Regina, Saskatchewan S4P 3T7
Telephone (toll-free): 1-800-667-3515
Dental (toll-free): 1-877-780-5458

Manitoba Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
391 York Avenue, Suite 300
Winnipeg, Manitoba R3C 4W1
Telephone (toll-free): 1-800-665-8507
Dental (toll-free): 1-877-505-0835

Ontario Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
1547 Merivale Road, 3rd floor
Postal Locator 6103A
Nepean, Ontario K1A OL3
Telephone (toll-free): 1-800-640-0642
Dental (toll-free): 1-888-283-8885

Quebec Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
Guy Favreau Complex, East Tower, Suite 404
200 René-Lévesque Boulevard West
Montréal, Québec H2Z 1X4
Telephone (toll-free): 1-877-483-1575
Dental (toll-free): 1-877-483-5501

Atlantic Region
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
1505 Barrington Street
Suite 1525, 15th Floor, Maritime Centre
Halifax, Nova Scotia B3J 3Y6
Telephone (toll-free): 1-800-565-3294
Dental (toll-free): 1-800-565-3294

Northern Region (NWT & Nunavut)
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
Qualicum Building
2936 Baseline Rd., Tower A – 4th Floor
Ottawa, Ontario K1A 0K9
Telephone (toll-free): 1-888-332-9222
Dental (toll-free): ext. 1

Northern Region (Yukon)
Non-Insured Health Benefits
First Nations and Inuit Health
Health Canada
300 Main Street, Suite 100
Whitehorse, Yukon Y1A 2B5
Telephone (toll-free): 1-866-362-6717
Dental (toll-free): 1-866-362-6719

FOR ORTHODONTIC SERVICES

Please mail your completed orthodontic forms and receipt(s) to the Orthodontic Review Centre.

Orthodontic Review Centre
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
55 Metcalfe Street, 5th Floor
Postal Locator 4005A
Ottawa, Ontario K1A 0K9
Telephone: 1-866-227-0943