Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Extended Health Benefits Claim Form

To be completed and returned to the Extended Health Benefits section of the Dept of Health

RECORD OF APPOINTMENT (s) to be signed by attending physician or designate or community health nurse

Physician/Community Nurse name	Date	Signature

PATIENT

NAME: ______________________________

BIRTH DATE (Y/M/D):______________________ HCP NO ______________________

CLAIMANT

NAME ______________________________

MAILING ADDRESS ______________________________

CITY/COMMUNITY ______________________________

POSTAL CODE ______________ HOME PHONE NO ______________________

WORK PHONE ______________________________

RELATIONSHIP TO PATIENT ______________________________

CLAIM DESCRIPTION (Attach original receipts)

Accommodation: ______________________________

Meals: ______________________________

Taxi: ______________________________

Prescriptions: ______________________________

Medical Supplies: ______________________________

Total: ______________________________

DECLARATION

I hereby certify that I have claimed for these benefits through my insurance plan and I now seeking reimbursement of the costs in excess of my coverage.

PLEASE PAY ☐ PATIENT ☐ THE CLAIMANT

Signature*: ______________________________ Date: ______________

* Claimant may sign if patient is under 18 or otherwise unable to sign

Return Completed Application to:

Nunavut Health Insurance Programs (NHIP)
Department of Health
Box 889
Rankin Inlet, NU X0C 0G0

For Office use
☐Create File
☐Add to Manual List
☐Letter