



**NIHB ORTHOTICS / CUSTOM FOOTWEAR / PROSTHETICS / PRESSURE GARMENTS:
PRIOR APPROVAL FORM**

Please check box if appropriate: Palliative Care Client OR Expected date of discharge from Health Care Facility: _____

Section 1: Client Information

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID #:	Band #:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Address:		Phone #:
City:	Province / Territory:	Postal Code :

Section 2: Parent/ Legal Guardian/Representative (If the client is under 18 months of age and not registered, please provide parent's information.)

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID#:	Band #:	Phone #:

Section 3: Prescriber Information (PLEASE PRINT)

Name and Title:	Licence #:
Phone #:	Fax #:

Section 4: Client Health Information

Diagnosis:
Explanation of benefit requirement and specific details of item to be provided (MUST BE COMPLETED):
Will a follow up assessment be provided? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this item for a: Permanent Condition <input type="checkbox"/> or Temporary Condition <input type="checkbox"/> * Any additional information that supports this request can be attached to this form or on a separate sheet so as not to delay the review of this request.
Is the benefit requested due to the result of an injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:
Where did the injury occur? Home <input type="checkbox"/> Work <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other <input type="checkbox"/> When did the injury occur?
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide the details:
Is the patient living in a long term care facility? Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 5: Equipment or Supplies Requested

Description of Device (manufacturing technique, materials to be used, side of body, itemized replacement parts if it is a repair and details of warranty)	Benefit Code	Quantity	Cost	➤ Manufacturer Name (In-house or external) ➤ Item Code # ➤ Class Type for orthoses and custom footwear

Section 6: Provider/Fitter Information (PLEASE PRINT)

Provider Name:	Provider #:
Fitter Name:	Specialty:
Phone #:	Fax #:
I hereby certify that the information provided above is true and complete. The NIHB Program reserves the right to request this form for audit purposes.	
Provider Signature:	Date:



Privacy statement: The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For more information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at www.tbs-sct.gc.ca/hgw-cgf/oversight-surveillance/atip-airpr/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

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