Indigenous Services Canada | Services aux Autochtones Canada

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NIHB GENERAL MEDICAL SUPPLIES AND EQUIPMENT 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 ☐ F ☐
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): * Any additional information that supports this request can be attached to this form or on a separate sheet.	
Is the benefit requested due to the result of an injury? Yes ☐ No ☐ If **yes**, please complete the following:	
Where did the injury occur? Home ☐ Work ☐ Motor Vehicle Accident ☐ Other ☐	When did the injury occur?
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes ☐ No ☐ If **yes**, provide the details:	
Is the client living in a long term care facility? Yes ☐ No ☐	Client height:_____ Client weight:_____

Section 5: Equipment or Supplies (For items that are distributed by package/box, please indicate the number of units per package/box, (e.g. 20 diapers per package). For items of different sizes or volumes (e.g. 3gm tube, 5gm tube, 3.5ml packets, small, medium, large,…), indicate the volume or size requested.)

Item Description, Manufacturer Name, Product Code #, Size and Type (If applicable)	Benefit Code	Quantity	Actual Acquisition Cost (per unit)	Mark-up	Total Cost	Start Date	End Date

Section 6: Provider Information (PLEASE PRINT)

Name and Title:	Provider #:
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-aiprp/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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