First Nations and Inuit Health Branch
Non-Insured Health Benefits (NIHB) Program

CLIENT REIMBURSEMENT REQUEST
MEDICAL TRANSPORTATION

Privacy Statement

The personal information you provide to ISC is governed in accordance with the *Privacy Act* (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). We only collect the information needed to administer the NIHB Program and IRS RHSP. 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 InfoSource (http://www.aandc-aadnc.gc.ca/eng/1100100011039/1100100011040). 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 at 819-953-3947 or at aadnc.aiprpdemande-atiprequest.aandc@canada.ca. 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.

- Please read Instructions before completing form.
- For inquiries and mailing addresses, see Contact Information.
- Incomplete or unsigned forms cannot be processed and will be returned.

1. Client Information (Client attending appointment)

- Must be completed for all requests.
- Payment will be made to this person UNLESS section 2 is also completed.
- If the client is under the age of 16, you MUST also complete section 2.
- All information is mandatory except as noted.

Family Name	Given Name (including middle name)	Date of Birth (YYYYMMDD)

Client Identification Number (Status / "N" No.)	Mailing Address (Number/Street/Apartment/P.O. Box)

City/Town	Province/Territory	Postal Code	Telephone Number

Are you covered for any of these expenses under any other health plans/programs? ◯ Yes ◯ No

If yes, please attach a copy of a detailed statement or explanation of benefits form from all other plans/programs.

Make payment to: ◯ Client ◯ Other Payee (if selected, complete section 2)	Inquiries to be sent to: ◯ Client ◯ Other Payee

2. Other Payee Information (If payment is not to be made to person in section 1)

- Must be completed for a child under age 16.
- Complete if the payment is to be made to someone other than the client listed in section 1 (e.g. an organization or community), otherwise, go to section 3.
- Providing this other person's client identification number helps find payment information for previous claims for direct payment, if any.
- All information is mandatory except as noted.

The client or parent/guardian agrees that payment will be made to the following individual/organization.

Family Name (or name of organization)	Given Name (including middle name)	Relationship to client receiving service

Payee Identification Number (Status / "N" No.; if applicable)	Mailing Address (Number/Street/Apartment/P.O. Box)

City/Town	Province/Territory	Postal Code	Telephone Number

3. Benefit / Service Received

- Must be completed for all requests, or use regional form.
- Attach the supporting documents listed in the Supporting Documents section of the instructions.
- If you are making a claim for more than one trip, fill in this section for each trip so that it is clear, to avoid delays in processing.
- Your request will be processed following NIHB Policy as outlined in the Medical Transportation Policy Framework.

Appointment Details

Date (YYYYMMDD)	Time (HH:MM)	Destination (City in which appointment occurred)
[-]		
[-]		
[-]		

[+] Add a Row

If travel prior-approved by NIHB, indicate Travel Authorization Number	Coverage being claimed for: ◯ Client ◯ Client and an eligible/approved escort

If coverage includes escort, provide escort's name (include NIHB identification number if available)

Claim Type	Date From (YYYYMMDD)	Date To (YYYYMMDD)	Amount Claimed

4. Authorization

Must be completed and signed, or the request will be returned to you unprocessed.

I am making a claim for the items listed in section 3. I authorize the release of any records that are relevant to the processing and payment of the attached claims held by the service provider to the Non-Insured Health Benefits Program, its agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information I have provided to be true and accurate and that it does not contain a claim for any benefit or service previously paid for by the Non-Insured Health Benefits Program or by any other plans/programs other than as noted in the statement or explanation of benefits. If section 2 is completed, I agree that the payment is to be made to the person listed there.

The **client must be at least 16 years of age** to sign. For children under 15 and under, the parent/guardian must sign.

Select one	Name of Client or Parent/Guardian (Print)	Signature	Date (YYYYMMDD)
◯ Client (Beneficiary) ◯ Parent/Guardian			