



Nisga'a Valley Health Authority
Protected when completed

Non-Insured Health Benefits for registered Nisga'a

DATE: _____

Phone Number: 250-633-5030

Fax Number: 250-633-2160

Medical Supplies & Equipment Request

PLEASE INCLUDE RX WITH REQUEST

Section 1. Patient Information

Last Name:				First Name:		Middle Initial:	
DOB:	MM /	DD /	YYYY	Email:			
Phone Number:						Sex:	Female Male Other
Address:							
Canada Life Benefits Number (GWL): Carrier 11 Policy Number: 051364 ID Number: 67							
<i>Assure Telus Health- We do not bill by status numbers</i>							

Section 2: Prescriber Information

Prescriber's Name:		License/Billing Number:	
Phone Number:		Fax Number:	

Section 3. Client Health Information

Diagnosis:

Explanation of benefit requirement and specific details of item to be provided (Must be complete)

Is the benefit requested due to the result of an injury: Yes or No (If yes, please complete the following)

Where did the injury occur: Home Work Other	When did the injury occur:
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Are any of these expenses being covered under any other public or private health care plan: Yes or No

Section 4. Equipment or Supplies Requested

Description of Device	Benefit Code	Quantity	Unit Cost	Cost
	99400			
	99400			
	99400			
	99400			

Section 5. Provider Information Total \$

Provider Name:		Provider Number:	
Phone Number:		Fax Number:	
Address:			
I hereby certify that the information is true and complete.			
COMPLETED BY: (PLEASE PRINT)			Date Submitted:
Prior Approval Number:		Amount Approved:\$	Date:

FOR BILLING PURPOSES: PLEASE SEND SIGNED PRIOR APPROVAL FORM, ALONG WITH AN INVOICE/RECEIPT
BY SIGNING THIS FORM, BOTH CLIENT AND PROVIDER CERTIFY THAT SERVICES WERE PROVIDED TO NVHA CLIENT

PROVIDER SIGNATURE AND DATE	CLIENT SIGNATURE AND DATE
MS&E Assessor: <input type="checkbox"/> CLIENT IS ELIGIBLE <input type="checkbox"/> CLIENT IS NOT ELIGIBLE <input type="checkbox"/> OVER MY LIMIT: \$	
NHB Adjudicator: <input type="checkbox"/> CLIENT IS ELIGIBLE <input type="checkbox"/> CLIENT IS NOT ELIGIBLE <input type="checkbox"/> OVER MY LIMIT: \$	
NHB Director: <input type="checkbox"/> CLIENT IS ELIGIBLE <input type="checkbox"/> CLIENT IS NOT ELIGIBLE <input type="checkbox"/> OVER MY LIMIT: \$	

THIS REQUEST CAN ALSO BE SUBMITTED BY EMAIL: ashley.green@nisgahealth.bc.ca
cc: nhbreception@nisgahealth.bc.ca
PLEASE FOLLOW UP WITH OUR OFFICE IN 2 BUSINESS DAYS