



NON-STATUS HEALTH BENEFIT REQUEST & AUTHORIZATION

PRIVACY ACT STATEMENT

Information collected on, and disclosed pursuant to, this document is collected pursuant to the Indian and Northern Affairs Canada (INAC) *Social Development Policy and Procedures Manual, BC Region* for the purpose of determining eligibility for assistance and will be maintained pursuant to the *Privacy Act* and described in the personal information bank INA-PPU-240. The accuracy of the information in this document may be checked by comparing it against information held by any federal or provincial department or agency or any private agency.

Note: Status Indians receive health benefits through the Medical Services Branch of Health Canada and these benefits include dental care, prescriptions, optical, medical supplies and more. For more information, visit the Health Canada web site at www.hc-sc.gc.ca/fniah-spnia/index-eng.php or call toll free at 1-800-317-7878.

Please complete in full. Please print clearly.

Administering Authority:

Number:

SECTION A: NON-STATUS CLIENT INFORMATION – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER

Client's Last Name		Client's First Name		(√) ONE of the following: <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Dental <input type="checkbox"/> Optical <input type="checkbox"/> Other (specify): _____
Address		Postal Code	Personal Health Number	
Telephone Number	Date of Birth	Type of income assistance being collected?		

SECTION B: SERVICE INFORMATION – TO BE COMPLETED BY PRACTITIONER (DENTAL/OPTICAL/PHARMACIST/OTHER)

Note: Authorization may not be converted to cash or transferred to another person. It must be presented for goods/services by the person authorized to purchase. (NO SUBSTITUTIONS OR CASH REFUNDS ARE ALLOWED)

Please describe the services or supplies you are recommending, with the estimated cost:

Date	Qty.	FeeCode	Description of Goods/Services	Estimated Amount

If these goods/services have previously been provided, list dates and amounts (e.g., Dental treatment - March 2010 - \$189.00):

Supplier Name	Supplier Phone ()	Supplier Fax Number ()
Supplier Signature	Supplier Mailing Address	Postal Code

Please contact the Band Social Development Worker if you have any billing enquires or questions.

SECTION C: AUTHORIZATION FOR GOODS OR SERVICE – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER

I have examined the written request and supporting documentation carefully as per Chapter 10, Non-Status Health Benefits policy and:

Approve the request for the non-status income assistance client until _____, 20____ for the amount of \$_____.

Deny the request based on the following reasons:

Note: Please ensure that all required documentation (i.e., invoices, lab slips and/or prescriptions) is attached to the form.

Approval limit for amount **below** \$500.00

Signature of Band Social Development Worker Date Signed

I have examined the written request and supporting documentation carefully as per Chapter 10, Non-Status Health Benefits policy and:

Approve the request for the non-status income assistance client until _____, 20____ for the amount of \$_____.

Deny the request based on the following reasons:

Note: Please ensure that all required documentation (i.e., invoices, lab slips and/or prescriptions) is attached to the form.

Approval limit for amount **above** \$500.00

Signature of Funding Services Officer (if required) Date Signed