NUNATSIAVUT
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Non-Insured Health Benefits (NIHB) Client Reimbursement Request Form

Information you need to include with your completed client reimbursement form can be found on the next page of this form. **Please note** that all NIHB policies and requirements for coverage apply. **All requests for reimbursement of eligible benefits must be made within one(1) year from the date of service.**
It is important to submit ALL related documents or there will be a delay in processing your claim. Please keep copies for your files.

Part 1 – Client Information (client receiving the service)

Surname:	**First and Middle Names:**
Address: **Apt.:**	**Identification Number (N#): N**
City: **Postal Code:**	**Telephone number: ( )**
Province/Territory:	**Date of Birth:** (YYYY/MM/DD)
Email Address:	
Are you covered for any of these expenses under any other health plan(s)/program(s)? No ◯ Yes ◯ **If Yes**, please attach a copy of a detailed statement or explanation of benefits from all other plan(s)/program(s).	

Part 2 – Parent, Guardian or Person to whom payment should be made

Please provide the name and address of the person to whom payment should be made if different from client receiving the service. If client is under one year of age and not registered, please provide parent or guardian information. The person must also be over the provincial/territorial legal age.

Surname:	**First and Middle Names:**
Address: **Apt.:**	**Identification Number (N#): N**
City: **Postal Code:**	**Telephone number:**
Province/Territory:	**Date of Birth:** (YYYY/MM/DD)
Relationship to Client:	

Part 3 – Details of Claim

Instructions on what information is needed to be included with the completed client reimbursement form are listed on the next page. Fill in the total of **all** receipts for each category.

List Benefit Items Requested: (Prescription drugs, Medical Supplies and Equipment, Vision , or Dental/Orthodontic Benefits)	**Cost**
TOTAL AMOUNT CLAIMED:	**$ 0.00**

Part 4 – Authorization and Signature (Mandatory)

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to NIHB – NG, it's agents or contractors, or any appropriate health professional licensing or regulatory body for the purpose of administrative audit. I declare the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by NIHB – NG or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits.
Client, Parent, Guardian or Person having a legally recognized authority **Date:** (YYYY/MM/DD)
Print Name: **Signature:**

Forms that are not signed will be returned to the client for signature. All claims must include the client identification/N#.

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INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

FOR ALL BENEFITS:

- ❑ Original receipt(s) for proof of payment. Credit card/Debit (Interac) slips are not acceptable forms of proof of payment. Pharmacy claims must include a copy of the original prescription receipt obtained from the Pharmacy.
- ❑ Sign and complete all applicable parts of this NIHB – NG Client Reimbursement Form. Forms that are not signed will be returned to the client for signature. **Please see exceptions to the Dental / Orthodontic Benefits below:**
- ❑ If applicable, submit your detailed statement or explanation of benefits form from all other health plan(s)/program(s). Note: Original receipts are not required when submitting the detailed statement or explanation of benefits form as the primary insurer requires them. In such cases, a copy of the original receipt is acceptable.

In addition to the items listed above, please submit the specific requirements for the benefits listed below:

Prescription Drugs

- No additional information other than what is listed above is required.

Medical Supplies and Equipment, Vision and Eye Care

- A copy of your prescription.

Dental or Orthodontic Services **(Please note:** For the reimbursement of **Dental or Orthodontic Services only,** you may use the *NIHB Dental Claim Form (Dent-29 Form)* ***OR*** *and NIHB Client Reimbursement Request Form).* When using an ***NIHB Client Reimbursement Request Form*** you must also submit ***ONE*** of the following completed claim forms provided by the dental or orthodontic service provider:

- Association des Chirurgiens Dentistes du Quebec Dental Claim and Treatment Plan Form
- Standard Dental Claim Form
- Canadian Association of Orthodontics Information Form

Please note: All Orthodontic and Schedule-B procedure dental claims require prior approval or pre-determination. Please check with your dental provider or our Dental Analyst for further information/instructions.

- Proof of your medical appointment attendance.

MAILING INSTRUCTIONS

For all reimbursements, please mail your completed form(s) and receipt(s) to the following address:

Nunatsiavut Government (NG)
Department of Health and Social Development (DHSD)
Non-Insured Health Benefits (NIHB)
218 Kelland Drive
P.O. Box 496, Station C
Goose Bay, N.L.
A0P 1C0

Telephone (toll-free): 1-866-606-9750 or (709) 896-9750

Facsimile: Pharmacy/Dental/Vision and Eye Care: (709) 896-9670