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Indigenous Services Canada | Services aux Autochtones Canada

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MENTAL HEALTH COUNSELLING SERVICES PRIOR APPROVAL/CLAIM FORM

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NON-INSURED HEALTH BENEFITS FOR ELIGIBLE FIRST NATIONS AND INUIT.
THIS IS A DUAL-PURPOSE FORM FOR SUBMITTING A PRIOR APPROVAL OR CLAIM. PLEASE ENSURE YOU COMPLETE THE APPROPRIATE FIELDS AS INDICATED.

☐ PRIOR APPROVAL (PA) - COMPLETE PARTS 1 & 2 AND SUBMIT PA REQUEST TO NIHB REGIONAL OFFICE, SEE COORDINATES BELOW

☐ CLAIM - COMPLETE PARTS 1 & 3 AND SUBMIT CLAIM TO EXPRESS SCRIPTS CANADA, SEE COORDINATES BELOW

PART 1 – CLIENT/PROVIDER INFORMATION (TO BE COMPLETED BY THE CLIENT/PROVIDER)

CLIENT INFORMATION

SURNAME _____ GIVEN NAME _____

ADDRESS _____ APT. _____ CITY _____

PROVINCE/TERRITORY _____ POSTAL CODE _____ PHONE NUMBER _____

CLIENT IDENTIFICATION NUMBER* _____ DATE OF BIRTH (YYYY-MM-DD) _____

PROVIDER INFORMATION (NAME, ADDRESS, PHONE NUMBER, PROVIDER NUMBER, OFFICE ID)

_____

_____

_____

_____

_____

*EXPLANATION OF CLIENT IDENTIFICATION NUMBER:

-REGISTERED FIRST NATIONS, USE 10-DIGIT REGISTRATION NUMBER (ALSO KNOWN AS STATUS, BAND OR TREATY NUMBER)
-INUIT CLIENTS USE 'N NUMBER' OR TERRITORIAL HEALTH CARD NUMBER
-FOR CHILDREN LESS THAN 18 MONTHS OF AGE WITHOUT THEIR OWN IDENTIFICATION NUMBER, PROVIDE A PARENT'S CLIENT IDENTIFICATION NUMBER.

OFFICE VERIFICATION/SIGNATURE OF PROVIDER: _____

SERVICE CODE	SERVICE NAME
MHA01	INITIAL ASSESSMENT, INDIVIDUAL
MHA04	INITIAL ASSESSMENT, TELEHEALTH
MHC01	COUNSELLING SESSION, INDIVIDUAL
MHC02	COUNSELLING SESSION, FAMILY (RETIRED)
MHC03	COUNSELLING SESSION, GROUP
MHC04	COUNSELLING SESSION, TELEHEALTH

PART 2 – PRIOR APPROVAL REQUEST TO BE COMPLETED BY PROVIDER

EVERY 12 MONTHS, COVERAGE IS AVAILABLE FOR UP TO 22 HOURS OF COUNSELLING (TWO HOURS OF INITIAL ASSESSMENT, UP TO 20 HOURS OF COUNSELLING)

ASSESSMENT/ COUNSELLING START DATE (YYYY-MM-DD)	SERVICE CODE (SEE ABOVE)	SERVICE NAME (SEE ABOVE)	DURATION (HOURS)	HOURLY RATE ($)

PART 3 – CLAIM SUBMISSION TO BE COMPLETED BY THE PROVIDER

ALL CLAIMS, REGARDLESS OF SUBMISSION METHOD, INCLUDING DOCUMENTATION TO SUPPORT COORDINATION OF BENEFITS (IF APPLICABLE), MUST BE RECEIVED BY ESC WITHIN ONE (1) YEAR FROM THE DATE OF SERVICE TO BE ELIGIBLE FOR PAYMENT. CLAIMS OLDER THAN ONE (1) YEAR FROM THE DATE OF SERVICE WILL BE REJECTED.

DOES THE CLIENT HAVE ACCESS TO COVERAGE FOR MENTAL HEALTH COUNSELLING SERVICES PROVIDED UNDER ANY OTHER PRIVATE GROUP INSURANCE, WORKERS COMPENSATION BENEFITS OR GOVERNMENT PLAN?

☐ NO ☐ YES IF YES, PLEASE PROVIDE:

POLICY NUMBER: _____ NAME OF INSURING PLAN OR AGENCY: _____

WHERE A CLIENT HAS OTHER COVERAGE, AN EXPLANATION OF BENEFITS OR OTHER WRITTEN CONFIRMATION FROM THE OTHER CARRIER WILL BE REQUIRED BEFORE A NIHB CLAIM CAN BE PROCESSED.

PRIOR APPROVAL NUMBER (8 DIGITS): _____ | *IF APPLICABLE BY PROFESSION*

DATE OF SERVICE (YYYY-MM-DD)	SERVICE CODE (SEE ABOVE)	SERVICE NAME (SEE ABOVE)	DURATION (HOURS)	HOURLY RATE ($)	TAX CLAIMED (PLEASE INDICATE WITH A CHECK)
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

SERVICE DATES NOTED ABOVE MUST MATCH CLIENT ATTENDANCE IN THE PROVIDER RECORDS

I UNDERSTAND THAT THIS CLAIM IS FOR THE SERVICES NOTED ABOVE WHICH HAVE BEEN PROVIDED TO ME.

I AUTHORIZE THE RELEASE OF ANY RECORDS THAT ARE RELEVANT TO THE PROCESSING AND PAYMENT OF THIS CLAIM, HELD BY THE SERVICE PROVIDER TO INDIGENOUS SERVICES CANADA, ITS AGENTS OR CONTRACTORS, OR ANY APPROPRIATE HEALTH PROFESSIONAL LICENSING OR REGULATORY BODY FOR THE PURPOSES OF ADMINISTRATIVE REVIEW.

SIGNATURE OF CLIENT (PARENT/GUARDIAN): _____

PAYMENT WILL BE MADE TO THE PROVIDER UNLESS INDICATED BELOW

☐ PAY CLIENT/GUARDIAN: PLEASE PROVIDE PAYEE NAME AND ADDRESS IF DIFFERENT FROM CLIENT. PAYEE MUST BE 16 YEARS OF AGE OR OLDER.

_____ _____

SURNAME GIVEN NAME

_____ _____

ADDRESS APT/UNIT#

_____ _____ _____

CITY PROVINCE/TERRITORY POSTAL CODE

PRIOR APPROVAL SUBMISSION
PLEASE SUBMIT TO THE APPLICABLE INDIGENOUS SERVICES CANADA REGIONAL OFFICE, AS LISTED BELOW

ATLANTIC REGION (NB, NS, NL, PEI)

NON-INSURED HEALTH BENEFITS
MARITIME CENTRE
1505 BARRINGTON STREET, SUITE 1525
HALIFAX, NS B3J 3Y6

TOLL FREE: 1-800-565-3294
FAX (TOLL FREE): 1-866-963-7700

QUÉBEC REGION

NON-INSURED HEALTH BENEFITS
200 RENÉ LÉVESQUE BOULEVARD WEST
GUY-FAVREAU COMPLEX
EAST TOWER, SUITE 202
MONTRÉAL, QC H2Z 1X4

TOLL FREE: 1-877-483-1575
(IN MONTRÉAL): 1-514-283-1575
FAX (TOLL FREE): 1-855-244-4470
FAX (IN MONTREAL): 1-514-283-7762

ONTARIO REGION

NON-INSURED HEALTH BENEFITS
SIR CHARLES TUPPER BUILDING
2720 RIVERSIDE DR., 4TH FLOOR
ADDRESS LOCATOR 6604E
OTTAWA, ON K1A 0K9

TOLL FREE: 1-800-881-3921
FAX (TOLL FREE): 1-800-806-6662

MANITOBA REGION

NON-INSURED HEALTH BENEFITS
STANLEY KNOWLES FEDERAL BUILDING
391 YORK AVENUE, SUITE 300
WINNIPEG, MB R3C 4W1

TOLL FREE: 1-800-665-8507
FAX (TOLL FREE): 1-800-289-5899

SASKATCHEWAN REGION

NON-INSURED HEALTH BENEFITS
ALVIN HAMILTON BUILDING
1783 HAMILTON ST., ROOM 098
REGINA, SK S4P 2B6

TOLL FREE: 1-866-885-3933
FAX: 1-306-780-3878

ALBERTA REGION

NON-INSURED HEALTH BENEFITS
CANADA PLACE
9700 JASPER AVENUE, SUITE 730
EDMONTON, AB T5J 4C3

TOLL FREE: 1-800-232-7301
FAX: 1-833.897.5808

NORTHERN REGION

NORTHWEST TERRITORIES AND NUNAVUT OFFICE

NON-INSURED HEALTH BENEFITS
2720 RIVERSIDE DRIVE
ADDRESS LOCATOR: 6604C
OTTAWA, ON K1A 0K9

TOLL FREE: 1-888-332-9222
FAX (TOLL FREE): 1-800-949-2718

YUKON OFFICE

NON-INSURED HEALTH BENEFITS
300 MAIN STREET, SUITE 100
WHITEHORSE, YT Y1A 2B5

TOLL FREE: 1-866-362-6717
(IN WHITEHORSE):1-867-393-3800
FAX (TOLL FREE): 1- 866-225-0569

BRITISH COLUMBIA (INUIT AND NON-RESIDENT FIRST NATIONS)

NON-INSURED HEALTH BENEFITS
CANADA PLACE
9700 JASPER AVENUE, SUITE 730
EDMONTON, AB T5J 4C3

TOLL FREE: 1-800-232-7301
FAX: 1-833.897.5808

First Nations residents of British Columbia
Contact the First Nations Health Authority (FNHA)
support line 1-855 550-5454

CLAIM SUBMISSION FOR PROVIDERS AND CLIENTS
PLEASE SUBMIT TO:

MAIL: EXPRESS SCRIPTS CANADA
NIHB OTHER BENEFITS
PO BOX 1358, STATION K
TORONTO, ONTARIO M4P 3J4

OR

FAX: 1-888-249-6098

PLEASE MAKE A COPY OF THE COMPLETED FORM AND RETAIN FOR YOUR FILES.