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### MENTAL HEALTH COUNSELLING SERVICES PRIOR APPROVAL/CLAIM FORM

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			PROVIDER INFORMATION (NAME, ADDRESS, PHONE NUMBER, PROVIDER NUMBER, OFFICE ID)		
SURNAME _____		GIVEN NAME _____	_____		
ADDRESS _____		APT. _____	CITY _____		_____
PROVINCE/TERRITORY _____	POSTAL CODE _____	PHONE NUMBER _____		_____	
CLIENT IDENTIFICATION NUMBER* _____		DATE OF BIRTH (YYYY-MM-DD) _____	_____		
			_____		
			_____		

**\*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 TWO YEARS OLD 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 (REMOVED)
MHC03	COUNSELLING SESSION, GROUP
MHC04	COUNSELLING SESSION, TELEHEALTH
MHC05	COUNSELLING SESSION, COUPLES/GROUP OF TWO

#### 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)
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

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**

<p><b>ATLANTIC REGION (NB, NS, NL, PEI)</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> 40 HAVELOCK STREET AMHERST, NS B4H 3Z3</p> <p><b>TOLL FREE: 1 800 565-3294</b> <b>FAX (TOLL FREE): 1 866 963-7700</b></p>	<p><b>QUÉBEC REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> GUY-FAVREAU COMPLEX 200 RENÉ LÉVESQUE BOULEVARD WEST EAST TOWER, SUITE 202 MONTRÉAL, QC H2Z 1X4</p> <p><b>TOLL FREE: 1 877 483-1575</b> <b>(IN MONTRÉAL): 1 514 283-1575</b> <b>FAX (TOLL FREE): 1 855 244-4470</b> <b>FAX (IN MONTREAL): 1 514 283-7762</b></p>	<p><b>ONTARIO REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> BENEFITS UNIT 10 WELLINGTON STREET – SUITE 1455 ADDRESS LOCATOR: 6604C GATINEAU, QC K1A 0H4</p> <p><b>TOLL FREE: 1 800 881-3921</b> <b>FAX (TOLL FREE): 1 800 806-6662</b></p>		
<p><b>MANITOBA REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> STANLEY KNOWLES FEDERAL BUILDING 391 YORK AVENUE, SUITE 300 WINNIPEG, MB R3C 4W1</p> <p><b>TOLL FREE: 1 800 665-8507</b> <b>FAX (TOLL FREE): 1 800 289-5899</b></p>	<p><b>SASKATCHEWAN REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> ALVIN HAMILTON BUILDING 1783 HAMILTON ST., ROOM 098 REGINA, SK S4P 2B6</p> <p><b>TOLL FREE: 1 866 885-3933</b> <b>FAX: 1 306 780-3878</b></p>	<p><b>ALBERTA REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> CANADA PLACE 9700 JASPER AVENUE, SUITE 730 EDMONTON AB T5J 4C3</p> <p><b>TOLL FREE: 1 800 232-7301</b> <b>FAX: 1 833 897-5808</b></p>		
<p align="center"><b>NORTHERN REGION</b></p> <table border="0"> <tr> <td data-bbox="138 898 544 1186"> <p><b>NORTHWEST TERRITORIES AND NUNAVUT OFFICE</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> 10 WELLINGTON STREET – SUITE 1455 ADDRESS LOCATOR: 6604C GATINEAU, QC K1A 0H4</p> <p><b>TOLL FREE: 1 888 332-9222</b> <b>FAX (TOLL FREE): 1 800 949-2718</b></p> </td> <td data-bbox="544 898 987 1186"> <p><b>YUKON OFFICE</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> 300 MAIN STREET, SUITE 100 WHITEHORSE, YT Y1A 2B5</p> <p><b>TOLL FREE: 1 866 362-6717</b> <b>(IN WHITEHORSE): 1 867 393-3800</b> <b>FAX (TOLL FREE): 1 866 225-0569</b></p> </td> </tr> </table>		<p><b>NORTHWEST TERRITORIES AND NUNAVUT OFFICE</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> 10 WELLINGTON STREET – SUITE 1455 ADDRESS LOCATOR: 6604C GATINEAU, QC K1A 0H4</p> <p><b>TOLL FREE: 1 888 332-9222</b> <b>FAX (TOLL FREE): 1 800 949-2718</b></p>	<p><b>YUKON OFFICE</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> 300 MAIN STREET, SUITE 100 WHITEHORSE, YT Y1A 2B5</p> <p><b>TOLL FREE: 1 866 362-6717</b> <b>(IN WHITEHORSE): 1 867 393-3800</b> <b>FAX (TOLL FREE): 1 866 225-0569</b></p>	<p><b>BRITISH COLUMBIA REGION</b></p> <p><b>NON-INSURED HEALTH BENEFITS</b> CANADA PLACE 9700 JASPER AVENUE, SUITE 730 EDMONTON, AB T5J 4C3</p> <p><b>TOLL FREE: 1 800 232-7301</b> <b>FAX: 1 833-897-5808</b></p> <p><b>FIRST NATIONS RESIDENTS OF BRITISH COLUMBIA</b> <b>CONTACT THE FIRST NATIONS HEALTH AUTHORITY</b> <b>(FNHA) SUPPORT LINE: 1 855 550-5454</b></p>
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**CLAIM SUBMISSION FOR PROVIDERS AND CLIENTS**

**PLEASE SUBMIT TO:**

MAIL: EXPRESS SCRIPTS CANADA                      OR                      FAX: 1 888 249-6098  
 NIHB OTHER BENEFITS  
 PO BOX 1358, STATION K  
 TORONTO, ONTARIO M4P 3J4

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