



Indigenous Services
Canada

Services aux
Autochtones Canada

PROTECTED B WHEN COMPLETED

MENTAL HEALTH COUNSELLING SERVICES PRIOR APPROVAL/CLAIM FORM

Clear

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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		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 A CHILD LESS THAN (2) TWO YEARS OLD WITHOUT THEIR OWN IDENTIFICATION NUMBER, PROVIDE THE CLIENT IDENTIFICATION NUMBER OF THE NIHB ELIGIBLE PARENT.

OFFICE VERIFICATION/SIGNATURE OF PROVIDER: _____

SERVICE CODE	SERVICE NAME
MHA01	INITIAL ASSESSMENT, INDIVIDUAL
MHA04	INITIAL ASSESSMENT, TELEHEALTH
MHA05	INITIAL ASSESSMENT, COUPLES/GROUP OF 2
MHC01	COUNSELLING SESSION, INDIVIDUAL
MHC02	COUNSELLING SESSION, FAMILY (RETIRED)
MHC03	COUNSELLING SESSION, GROUP
MHC04	COUNSELLING SESSION, TELEHEALTH
MHC05	COUNSELLING SESSION, COUPLES/GROUP OF 2

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 40 HAVELOCK STREET AMHERST, NS B4H 3Z3 TOLL FREE: 1 800 565-3294 FAX (TOLL FREE): 1 866 963-7700	QUÉBEC REGION NON-INSURED HEALTH BENEFITS GUY-FAVREAU COMPLEX 200 RENÉ LÉVESQUE BOULEVARD WEST 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 BENEFITS UNIT 10 WELLINGTON STREET - SUITE 1455 ADDRESS LOCATOR: 6604C GATINEAU, QC K1A 0H4 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 630 EDMONTON, AB T5J 4G2 TOLL FREE: 1 800 232-7301 FAX: 1 833 897-5808
NORTHERN REGION NORTHWEST TERRITORIES AND NUNAVUT OFFICE NON-INSURED HEALTH BENEFITS 10 WELLINGTON STREET - SUITE 1455 ADDRESS LOCATOR: 6604C GATINEAU, QC K1A 0H4 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 REGION NON-INSURED HEALTH BENEFITS CANADA PLACE 9700 JASPER AVENUE, SUITE 630 EDMONTON, AB T5J 4G2 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 PLEASE MAKE A COPY OF THE COMPLETED FORM AND RETAIN FOR YOUR FILES. OR FAX: 1 888 249-6098		