TO DOWNLOAD THIS FORM, CLICK THE BUTTON IN THE TOP RIGHT-HAND CORNER

NON-INSURED HEALTH BENEFITS (NIHB)
CLIENT REIMBURSEMENT FORM

Express Scripts Canada delivers Health Information and Claims Processing Services (HICPS) on behalf of Indigenous Services Canada's NIHB Program for the following benefits: **Pharmacy, Medical Supplies and Equipment, Dental Care (including Orthodontics), Vision Care and Mental Health Counselling**. Clients can request reimbursement in the following ways:

1. Online: Submit a request through the Express Scripts Canada NIHB Provider and Client Website at https://nihb-ssna.express-scripts.ca/**OR**
2. Mail or fax: Complete the attached form and mail or fax in your request.

Please note:

- This reimbursement form can be used for all NIHB benefits, except medical transportation. For medical transportation requests, refer to the NIHB Claims and Reimbursement web page.
- A separate NIHB Client Reimbursement form must be completed for each eligible client and for each type of benefit (e.g., one for dental, one for vision).
- To receive payment by direct deposit, please complete the Direct Deposit and Communication Preference Form for NIHB Clients located here: https://nihb-ssna.express-scripts.ca/en/0205140506092019/12/1206
- Payment to someone other than the client (e.g., an organization, community, or parent of a child under 16 years) can only be made by cheque.

GENERAL INSTRUCTIONS

- Requests for reimbursement must be received within **one year** of the date of service. All NIHB Program policies (including eligible rates) and requirements for coverage at the time the services were provided will be applied.
- To be eligible, the client must be a resident of Canada and the product or service must have been obtained in Canada.
- Refer to HOW TO SUBMIT section (page 3) to know where to send the completed form and obtain contact information for the NIHB Call Centre at Express Scripts Canada.
- In some cases, a First Nations or Inuit community, self-government, or health authority may be responsible for providing some or all NIHB benefits. **Do not use this form for these requests as they cannot be processed by Express Scripts Canada or the NIHB Program.** Such requests should be sent to the appropriate authority according to their established procedures (your regional office can provide contact information, if needed). These include:
    - Those served under self-government agreements or other arrangements, including Nisga'a (BC), Nunatsiavut (NL), Nunavik Inuit or James Bay Cree (beneficiaries living in the land claims region); and First Nations residents of BC who are clients of the First Nations Health Authority);
    - Akwesasne (ON) and Bigstone Cree Nation (AB), which manage all NIHB benefits for their members; and
    - Clients served by other First Nations and Inuit communities or organizations that deliver NIHB benefits directly to community members under a contribution agreement.

INSTRUCTIONS FOR COMPLETING THE FORM

- Fill out and **sign** the form. Parts 1, 3 and 4 are mandatory.
    Note: The client must provide their client identification number:
        - Registered First Nations, use 10-digit registration number (also known as a *status, band* or *treaty number*).
        - Inuit clients, use your 'N number' or Territorial Health Card number
        - A child less than two years old, without their own client identification number, provide a parent's client identification number.
    - Clients 16 years of age or older must sign the form. Payments can only be made to a person who is 16 years of age and older.
    - Payments, for a child under 16 years of age, are made to the parent or guardian indicated in part 2. For all benefits, clients can ask for the payment to be made to a community or organization when

completing part 2 (for example, your Band Office) . A form is to be used for one individual client only and cannot be used for multiple clients.
    - For all claims for a child under the age of 16 years, or to ask that the payment be made to someone other than the client, clients must also complete part 2.
    - Provide your address and phone number in case additional information is required to process your request.
- Include the required supporting documents as described in the SUPPORTING DOCUMENTS section (page 2).
- Once the form is filled out, signed and dated, make a copy of the form and all supporting documents for your records.
- Mail or fax the completed and signed form, along with supporting documents, to the address or fax number listed under HOW TO SUBMIT (page 3).

SUPPORTING DOCUMENTS

SUPPORTING DOCUMENTS ARE TO BE INCLUDED WITH THE COMPLETED AND SIGNED CLIENT REIMBURSEMENT FORM.

*Contact **the NIHB Call Centre at Express Scripts Canada** at 1 888 441-4777 for any inquiries regarding supporting documents.*

Required Information for ALL benefits:

- **Receipt(s**) must list client's full name, date of service, provider/office name, description of services, and proof of total amount paid. Receipts submitted without this information will be returned. Credit card/debit (interact) slips, cash register receipts or statements of account are not accepted.
- **If you have other health coverage** (such as through private group insurance, workers compensation benefits or another government plan), please submit either a detailed statement or *EXPLANATION OF BENEFITS (EOB) form* from all other health plans(s)/program(s) as well as a copy of receipts.

Supporting documents required for each benefit:

Pharmacy:
- Official prescription receipt (include first & last name, DIN, drug name, quantity, prescription number (RX), DOS, prescriber information, cost). Do not use the label from the bottle or the outside of the bag as it does not include this information.
- If you have other coverage, provide the EOB or detailed statement from the other plan(s). See note above.

Vision Care
- Copy of your prescription for all requests for corrective eyewear (this is used to calculate the "strength" of your lenses, which determines your coverage amount).
- Receipt(s) (must list client's full name, date of service, provider/office name, description of services, and proof of total amount paid).
- Exceptional coverage of eye exams and eyewear may require additional supporting documentation (refer to the Guide to Vision Care Benefits).
- If you have other coverage, provide the EOB or detailed statement from the other plan(s). See note above.

Medical Supplies and Equipment:
- Copy of your prescription written by an NIHB approved prescriber/recommender for the benefit.
- Receipt(s) (must list client's full name, date of service, provider/office name, description of services, and proof of total amount paid).
- Additional medical documentation listed on the MS&E Guide and benefit lists.
- If you have other coverage, provide the EOB or detailed statement from the other plan(s). See note above.

Dental Care (including Orthodontics):
- Receipt(s) (must list client's full name, date of service, provider/office name, description of services, and proof of total amount paid)
- A **completed** copy of one of the following forms, which must include office verification by your dental or orthodontic service provider:

- *Association des chirurgiens dentistes du Québec* Dental Claim and Treatment Plan Form.
- Standard Dental Claim Form.
- Canadian Association of Orthodontics Information Form.

Note: you may choose to submit a completed and signed NIHB Dental Claim Form (Dent-29 Form), in which case the Client Reimbursement Request form is not necessary.

- If you have other coverage, provide the EOB or detailed statement from the other plan(s). See note above.

Mental Health Counselling:

- Receipt(s) (must list client's full name, date of service, provider/office name, type of counselling services (e.g. individual, group), number of hours and proof of total amount paid)
- To confirm the service is eligible for reimbursement, refer to the Guide to Mental Health Counselling services.
- If you have other coverage, provide the EOB or detailed statement from the other plan(s). See note above.

INSTRUCTIONS

- Make a copy of the completed form and supporting documents for your records.
- Mail or fax the completed and signed form for each benefit, along with supporting documents, to the fax number or the corresponding address listed below.
- Contact the **NIHB Call Centre at Express Scripts Canada** at 1-888-441-4777 for any questions on submitting a client reimbursement request or on the status of your request.

SUBMIT ONLINE:

Create a Client web account and submit claims online for all benefits listed below. Visit the Express Scripts Canada NIHB Provider and Client Website at *https://nihb-ssna.express-scripts.ca*

SUBMIT BY MAIL:

PHARMACY:

EXPRESS SCRIPTS CANADA
PHARMACY BENEFIT
PO BOX 1353, STATION K
TORONTO, ON M4P 3J4

DENTAL (including ORTHODONTICS):

EXPRESS SCRIPTS CANADA
DENTAL BENEFIT
3080 YONGE STREET, SUITE 3002,
TORONTO, ON M4N 3N1

MEDICAL SUPPLIES AND EQUIPMENT:

EXPRESS SCRIPTS CANADA
MEDICAL SUPPLIES AND EQUIPMENT BENEFIT
PO BOX 1365, STATION K
TORONTO, ON M4P 3J4

MENTAL HEALTH COUNSELLING:

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

VISION CARE:

EXPRESS SCRIPTS CANADA
NIHB VISION CARE BENEFIT
PO BOX 1296, STATION K
TORONTO, ON M4P 3J4

SUBMIT BY FAX:

FAX NUMBER FOR ALL BENEFITS: 1-888-249-6098

For inquiries, please contact the NIHB Call Centre at Express Scripts Canada at 1-888-441-4777.

Clear Print

PROTECTED WHEN COMPLETED – B
Non-Insured Health Benefits (NIHB) Program

NIHB CLIENT REIMBURSEMENT FORM

See INSTRUCTIONS and SUPPORTING DOCUMENTS section before completing the form. For online, fax and mail information, see HOW TO SUBMIT. INCOMPLETE or UNSIGNED FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

PART 1 – CLIENT INFORMATION (WHO RECEIVED THE SERVICE)
Must be completed for all requests. Payment will be made to this person UNLESS part 2 is also completed. If the client is under the age of 16 years, you MUST also complete part 2. All information is mandatory.

Last Name:		First and Middle Names:
Identification Number of client (Status/N #):		Date of Birth (YYYY/MM/DD):
Address:	Apt.:	Telephone Number:
City:	Province/Territory:	Postal Code:

Are you covered for any of these expenses under any other health plan(s)/program(s)? **Yes** ☐ **No** ☐

If yes, please attach a copy of a detailed statement or ***explanation of benefits form*** from all other plan(s)/program(s).

Please make payment to: ☐ Client ☐ Other Payee listed in part 2 (if "Other Payee", complete part 2)

Inquiries to be sent to: ☐ Client ☐ Other Payee

PART 2 – OTHER PAYEE INFORMATION (WHO WILL BE PAID, IF NOT THE PERSON IN PART 1) (e.g. an organization, community, or parent/guardian of a child under 16 years.) Must be completed for a child under age 16 years. Please note that this form is for individual client reimbursements only and cannot be used for multiple clients. All information is mandatory.

The client or parent/guardian agrees that payment will be made to the following person or organization

Last Name (or name of organization):		First and Middle Names:	
Address: Apt.:		Telephone Number:	Relationship to client receiving service:
City:	Province/Territory:	Postal Code:	

PART 3 – BENEFIT / SERVICE RECEIVED (USE A DIFFERENT FORM FOR EACH BENEFIT TYPE)
Must be completed for all requests. Attach the supporting documents listed in the SUPPORTING DOCUMENTS section (page 2).

BENEFIT TYPE (Select One): ☐ Pharmacy ☐ Medical Supplies & Equipment ☐ Vision Care
☐ Dental ☐ Orthodontics ☐ Mental Health Counselling

LIST BENEFIT/SERVICE BEING CLAIMED	DATE OF SERVICE*	COST
TOTAL AMOUNT CLAIMED:		0.00

***NOTE: Requests must be RECEIVED within ONE YEAR of the date of service.**

PART 4 – SIGNATURE AND AUTHORIZATION
Must be completed and signed, or the request will be returned to you unprocessed.

I authorize the release of any records that are relevant to the processing and payment of the attached claims held by the service provider to the Non-Insured Health Benefits Program, its agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information I have provided to be true and accurate and that it does not contain a claim for any benefit or service previously paid for by the Non-Insured Health Benefits Program or by any other plan(s)/program(s) other than as noted in the statement or explanation of benefits. If part 2 is completed, I agree that the payment is to be made to the person listed there.

Client (beneficiary) ☐ Parent/Guardian ☐

Clients 16 years of age or older must sign. For children under 16 years, the parent/guardian must sign. **Note:** Payment to someone other than the client (e.g. an organization, community, or parent of a child under 16 years) can only be made by cheque.

_____	_____	_____
CLIENT or PARENT/GUARDIAN (Print Name)	Signature:	Date: (YYYY/MM/DD)

For inquiries, please contact NIHB Call Centre at Express Scripts Canada at 1-888-441-4777.