



Skeetchestn Extended Health Care Costs Reimbursement Form

PLEASE COMPLETE AND ATTACH ORIGINAL RECEIPT

Band Member Name (Claimant):

Birthdate: _____/_____/_____
Month Day Year

Mailing Address: _____
City/Province Postal Code

Has your address changed in the past year?
Yes / No

Was the Treatment the result of:

An injury at the Workplace? Yes / No
A motor Vehicle Accident? Yes / No

Phone number: _____

Email address: _____

Are any benefits or services provided covered under any other Insurance or Plan for the expenses claimed?

Yes No If yes, complete the following:

Policy holder or other Plan: _____

Employer: _____

Employers Insurance Company: _____

Policy and Contract number: _____

Is Payment to be made to the Provider of the Service?

Yes No

I hereby assign the benefits to the following provider:
Name: _____

Address: _____
Postal Code _____

I understand that the charges listed may not be covered or may exceed budgetary allowances for the Trust Funds. I understand that I am financially responsible to the above provider for the cost of the treatment or supplies.

Signature: _____
(or parent/guardian)

Date: _____

Band #: 687

Indicate the type of treatment, service or medical supplies/equipment and amount claimed:

	AMOUNT \$
Audiologist	_____
Chiropractor	_____
Clinical Psychologist/Counselling	_____
Crutches	_____
Dental Care	_____
Foot Orthotics	_____
Hearing Aids	_____
Podiatrist	_____
Physiotherapist	_____
Prescription medication	_____
Prescribed supplements and vitamins	_____
Orthopedics Shoes	_____
Osteopath	_____
Special Equipment	_____
Speech Therapist	_____
Other—Description	_____

***Patient name must appear on the original receipt.**

To help reduce administration expenses, receipts should be accumulated until they total at least \$30.00

Exclusions and limitation: (See policy for details)

- Vision care— Eyeglasses: maximum \$300 every 24 consecutive months.
- Orthodontics: Lifetime maximum amount \$1,100.00 (2 payments over 2 years)
- Cosmetic surgery: Not covered.
- Medical equipment: Lifetime maximum \$500.00
- Prescribed Supplements/Special Vitamins, maximum \$350/yr

OFFICE USE ONLY

Received (date) _____ Assessed (date) _____
Checked (Initials) _____ Audit (Initials) _____