Skeetchestn Extended Health Care Costs Reimbursement Form

PLEASE <u>COMPLETE</u> AND <u>ATTACH ORIGINAL RECEIPT</u>

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:

Phone number: _____

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

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 coost 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) _____