Northwest Territories Health and Social Services

HEALTH BENEFITS MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Section 1: Program Information

Extended Health Benefits ☐	Indigent Health Benefits ☐

Section 2: Client Information

Client's Surname:	Date of Birth:
Given Names(s):	NWTHC#

Section3: Prescriber Information

Prescriber's Name:	Billing #:
Telephone #:	Fax#:

Section 4: Client Health Information

EHB Program#/Diagnosis:
Explanation of benefit requirement and specific details of items to be provided (MUST BE COMPLETE)

Section 5: Equipment or Supplies Requested

Description of Device	Benefit Code	Qty	Cost

Section 6: Provider Information

Provider Name:	
Telephone #:	Fax #:

For Office Use Only

Prior Approval #:	Not Approved
Health Benefit Specialist Name:	
Comments:	