

NIHB GENERAL MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Section 1: Patient Information

Patient's Surname:		Date of Birth:	
Given Name(s):		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
Band #:	Family #:	Telephone #:	Client ID#:

Section 2: Prescriber Information

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

Section 3: Client Health Information

Diagnosis:
Explanation of benefit requirement and specific details of item to be provided (MUST BE COMPLETED):
Is the benefit requested due to the result of an injury: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:
Where did the injury occur: Home <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> When did the injury occur:
Are any of these expenses covered under any other public or private health care plan: Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 4: Equipment or Supplies Requested

Description of Device	Benefit Code	Qty	Cost

Section 5: Provider Information

Provider Name:	Provider #:
Telephone #:	Fax#:
I hereby certify that the information is true and complete.	
Provider Signature:	Date:

FOR OFFICE USE ONLY

P. A.#:	User ID#:
Office Telephone #:	Office Fax #: