

IMPORTANT INFORMATION

This personal information is being collected under the authority of the Government of the Northwest Territories Extended Health Benefits Policy and Directive and will be used to determine program benefit entitlement. This information is protected by the privacy provisions of the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, contact the Department of Health and Social Services (see contact information provided on this form).
NOTE: If more space is required, enter additional information on a separate sheet of paper and attach it to this application.

1. You must access employer or similar plans first.

PROOF OF ATTENDANCE

Patient's Name		Note: If patient has more than one appointment, a letter from the attending physician will be required.	
Location of Medical/Clinic Appointment		Date of Appointment (y/m/d)	Time of Appointment
Health Professional Name/Title	Signature X	Date (y/m/d)	

EXPENSE CLAIM

Claimant's Surname	Given Names	Init.	HCP Number			
Mailing Address	City/Community	Postal Code	Home Phone No. ()			
Type of Claim						
<input type="checkbox"/> Patient Claim		If you are claiming expenses as a non-medical escort , provide the following:				
<input type="checkbox"/> Non-Medical Escort Claim		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Patient's Surname</td> <td>Given Name(s)</td> <td>Init.</td> <td>HCP Number</td> </tr> </table>	Patient's Surname	Given Name(s)	Init.	HCP Number
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DETAILS OF EXPENSES (Original receipts are required)

Date (y/m/d)	Details	Transportation	Accommodation	Meals	Other

NOTE: Include all original receipts with this claim and the Pre-Approved Medical Travel Request.

Sub-Totals

1.	2.	3.	4.
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TOTAL (1+2+3+4)

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APPLICANT'S DECLARATION

I hereby certify that the information given is true, correct and complete to the best of my knowledge. I consent to the release of my personal information to the Extended Health Benefits program for the purposes of determining initial and continued eligibility for extended health benefits coverage.

X

Applicant's Signature (Parent / Guardian)

Date (y/m/d)

RETURN COMPLETED FORM TO:

Department of Health and Social Services
 HEALTH BENEFIT PROGRAMS
 BAG #9, INUVIK NT X0E 0T0

Phone: (867) 777-7400
 Toll Free: 1-800-661-0830