INTERIM FEDERAL HEALTH PROGRAM
MEDICAL/GENERAL SERVICES CLAIM FORM

☐ PRIOR APPROVAL ☐ POST APPROVAL

PROTECTED "B" (WHEN COMPLETED)

1. CLIENT INFORMATION

Name ______________________________

Client ID Number | | | | | | | | | |

Date of Birth ______________________ Day Month Year

2. PROVIDER INFORMATION

Specialty (if applicable) ______________________________

Name of Referring Prescriber (if you are a specialist) ______________________________

Name ______________________________ Provider Number ______________________

Address ______________________________

City ______________________ Province ______________________ Postal Code ______________________

Telephone Number ______________________ Fax Number ______________________

3. CLAIM INFORMATION

Invoice Number (from your own office)	Date of Service (D / M / Y)	Fee Code	Units of Time	ICD 9, ICD 10 Code, or Medical Diagnosis	P *	Amount Claimed
					TOTALS:	

* P - Enter Prescriber Designation (i.e. MD)

The IFHP does not cover the cost of health care services or products that a person may claim (even in part) under a public or private health insurance plan. The IFHP does not coordinate benefits with other insurance plans or programs therefore, co-payments are not possible.

4. ADDITIONAL INFORMATION FOR PRIOR/POST APPROVAL

Provide clinical details/justification and/or attach supporting documentation.

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5. CERTIFICATION

I hereby certify that the above services have been rendered, that the claim was made in accordance with the terms and conditions of the IFHP and that any information relating to these services as well as copies and supporting documentation of this information, may be obtained by Medavie Blue Cross.

Provider's Original Signature/Stamp ______________________________ Date ______________

I certify that the information above is accurate and the services described above have been received.

Client's Signature ______________________________ Date ______________

The purpose for the collection of personal information by Medavie Blue Cross will be solely for the administration of IFHP services and benefits. Medavie Blue Cross will comply with the requirements of the Personal Information Protection and Electronic Documents Act and the Privacy Act when collecting, using and disclosing personal information. Personal information will not be disclosed to third parties except as authorized by law.

IMPORTANT: This claim form must be completed in full or the claim may be rejected. A copy of this form must be kept on file for audit purposes.

Immigration, Refugees and Citizenship Canada
Immigration, Réfugiés et Citoyenneté Canada

MAIL TO
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