



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

2. PROVIDER INFORMATION

Specialty (if applicable)
Name of Referring Prescriber (if you are a specialist)
Name
Address
City
Province
Postal Code
Telephone Number
Fax Number

3. CLAIM INFORMATION

Table with 7 columns: Invoice Number, Date of Service, Fee Code, Units of Time, ICD 9, ICD 10 Code, P*, Amount Claimed

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

TOTALS:

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.

4. ADDITIONAL INFORMATION FOR PRIOR/POST APPROVAL

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

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.

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
Interim Federal Health Program
Medavie Blue Cross
644 Main Street PO Box 6000 Moncton NB E1C 0P9
Toll-free Number: 1-888-614-1880

Year	Month	Day	Event	Location	Notes
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