ᑲᑐᑎᓗᒍ ᓄᓇᕗᑦ ᐱᕈᖅᐸᓕᐊᑎᓪᓗᒍ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble
Nunavut

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Extended Health Benefits Claim Form

To be completed and returned to the Extended Health Benefits section of the Dept of Health

RECORD OF APPOINTMENT (s) to be signed by attending physician or designate or community health nurse

Physician/Community Nurse name	Date	Signature

PATIENT

NAME: _____

BIRTH DATE (Y/M/D):_____HCP NO _____

CLAIMANT

NAME _____

MAILING ADDRESS _____

CITY/COMMUNITY _____

POSTAL CODE _____ HOME PHONE NO _____

WORK PHONE _____

RELATIONSHIP TO PATIENT _____

CLAIM DESCRIPTION (Attach original receipts)

Accommodation: _____

Meals: _____

Taxi: _____

Prescriptions: _____

Medical Supplies: _____

Total: _____

DECLARATION

I hereby certify that I have claimed for these benefits through my insurance plan and I now seeking reimbursement of the costs in excess of my coverage.

PLEASE PAY ☐ PATIENT ☐ THE CLAIMANT

Signature*: _____ Date: _____

* Claimant may sign if patient is under 18 or otherwise unable to sign

Return Completed Application to:

Nunavut Health Insurance Programs (NHIP)
Department of Health
Box 889
Rankin Inlet, NU X0C 0G0

For Office use
☐Create File
☐Add to Manual List
☐Letter