



## INTERIM FEDERAL HEALTH PROGRAM OPTICAL SERVICES CLAIM FORM

PRINT CLEARLY IN BLOCK LETTERS

I. CLIENT INFORMATION	
Last Name	First Name
Date of Birth (DD/MM/YYYY) / /	Client Identification Number (see IFH Certificate – IMM1442) - - - - -

II. PROVIDER INFORMATION	
Last Name, First Name	Company Name
Provider #	Email Address
Address	
City	Province
	Postal Code - - - - -
Phone Number ( ) -	Fax Number ( ) -

PLEASE SUBMIT OPTICAL INFORMATION AND VISUAL ACUITY (EXPRESSED AS FRACTION)

III. OPTICAL INFORMATION	OD :	OS :	
<b>Visual Acuity</b>  <input type="checkbox"/> With existing eyewear  <input type="checkbox"/> Has no existing eyewear/unaided	NEAR		
	OD	OS	
	20	20	
	FAR		
OD	OS	OD	OS
20	20	20	20

IV. SERVICE INFORMATION			
Your Invoice Number	Service Date (DD/MM/YYYY)	Service Type	Amount Claimed
		<input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocals <input type="checkbox"/> Single Vision with Astigmatism <input type="checkbox"/> Bifocals with Astigmatism <input type="checkbox"/> Other : _____	\$
		<input type="checkbox"/> Eye Exam (Diagnosis : _____) <input type="checkbox"/> Other : _____	\$
<b>TOTAL AMOUNT</b>			\$

Signature	Name (print)	Date / /
-----------	--------------	-------------

**MAIL/FAX CLAIMS TO :**  
 IFH Program Priority Processing  
 FAS Benefit Administrators Ltd.  
 9th Floor, 9707-110 Street  
 Edmonton, AB  
 T5K 2W8  
 FAX : 1-780-452-5388

**FOR PRE-APPROVAL FAX TO**  
 IFH/CIC AT :  
 1-800-362-7456

**IMPORTANT : This form must be  
 completed in full or the claim may be  
 declined**