

IFH Program - Hospital Services Claim Form

Prior Approval
 Medical Director, IFH/CIC
 365 Laurier Avenue West
 Jean Edmonds Building
 South Tower, 14th Floor
 Ottawa, ON K1A 1L1
 FAX: 1-800-362-7456

Change of address
 Include written confirmation of change
 of address, including previous
 address

Hospital Stay

Hospital Services

**Are you submitting copies of
 eligibility documents?**

Yes

No, Eligibility already on file at FAS

And/Or

Resubmission of FAS Claim
 # _____

PRINT CLEARLY IN BLOCK LETTERS

REFUGEE/PATIENT	REFUGEE ID#:
LAST NAME	FIRST NAME
DATE OF BIRTH: MONTH: DAY: YEAR:	
IFH ELIGIBILITY: FROM: Month _____ Day _____ Year _____	
TO: Month _____ Day _____ Year _____ OR 9 see accompanying documents	

PROVIDER (TO WHOM CHEQUE IS MADE PAYABLE)	FAS PROVIDER #
NAME (LAST)	(FIRST)
ADDRESS	
CITY	PROVINCE
POSTAL CODE	PHONE NUMBER ()

INVOICE NUMBER (FROM YOUR OWN OFFICE)	FEE CODE OR SERVICE PROVIDED	ICD CODE	# ANAES/ BASIC TIME UNITS	DATE ADMITTED (MM/DD/YY)	DATE DISCHARGED (MM/DD/YY)	AMOUNT CLAIMED
						\$
						\$
						\$
						\$
						\$

DATE	SIGNATURE	PLEASE PRINT NAME HERE	TOTAL AMOUNT CLAIMED \$
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IMPORTANT: This form must be completed in full or the claim may be declined.