IFH Program - Pharmaceutical Services Claim Form

☐ **Prior Approval**
Medical Director, IFH/CIC
219 Laurier Street
3rd Floor
Ottawa, ON K1A 1L1
FAX: 1-800-362-7456

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

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** ☐ see accompanying documents

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

SERVICE DATE (MM/DD/YY)	DRUG NAME	DIN NUMBER	QTY	DOSAGE	COMPD DRUG? Y/N	INGR COST	DISP FEE	TOTAL AMOUNT CLAIMED
								$
								$
								$
								$
								$
								$

DATE	SIGNATURE	PLEASE PRINT NAME HERE	TOTAL AMOUNT CLAIMED $

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

MAIL TO: IFH PROGRAM PRIORITY PROCESSING,
FAS Benefit Administrators Ltd.
9707 - 110 Street, SUITE 901,
Edmonton, AB T5K 2W8

TOLL FREE: 1-800-770-2998

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