IFH Program - Medical 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

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 ( )
SPECIALTY (IF APPLICABLE)	NAME OF REFERRING PHYSICIAN (IF APPLICABLE)

INVOICE NUMBER (FROM YOUR OWN OFFICE)	**FEE CODE OR SERVICE PROVIDED**	**ICD CODE**	**SERVICE DATE (MM/DD/YY)**	**#ANAES/ BASIC TIME UNITS**	**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