IFH Program - Dental Predetermination Form

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 ( )

In order to consider your predetermination request, we require the following additional information:

1. Is the service indicated the initial placement of the appliance(s)? ☐ Yes ☐ No
   If Yes, which teeth were, or will be, extracted?
2. Date(s) of the extraction(s) of this tooth or teeth: Month: Day: Year:
3. Please advise if there are any missing teeth in the _____maxilla _____mandible which have not already been replaced and are therefore "empty spaces".
4. Please submit a brief note describing the condition of the involved tooth/teeth at the time of submission.
5. Please advise regarding Missing Teeth:

Tooth # and Surf.	Procedure Code

DATE	SIGNATURE	PLEASE PRINT NAME HERE

IMPORTANT: Reimbursement may be reduced to a less costly method of treatment, provided that it is consistent with good dental care.

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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