Conseil Cri de la santé et des services sociaux de la Baie James
Cree Board of Health and Social Services of James Bay

CREE NON-INSURED HEALTH BENEFITS
Reimbursement Claim Form

SECTION 1 CLAIMANT INFORMATION

NAME _____ **JBQNA NO.** _____

ADDRESS _____
STREET NAME, P.O. BOX COMMUNITY POSTAL CODE

TELEPHONE _____
HOME MOBILE WORK

EMAIL _____ **DIRECT DEPOSIT** ☐ INCLUDE VOID CHEQUE ☐

TRANSIT NO. _____ ACCT. NO. _____

SECTION 2 USER INFORMATION

NAME OF BENEFICIARY _____ **JBNQA NO.** _____

DATE OF BIRTH _____
YYYY-MM-DD

SECTION 3 TYPE OF BENEFIT

DESCRIPTION (VISION CARE, PRESCRIPTION DRUGS, MEDICAL SUPPLIES AND EQUIPMENT, DENTAL SERVICES) **AMOUNT CLAIM**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

IMPORTANT: FOR VISION CARE REIMBURSEMENT PLEASE ATTACH COPY OF THE PRESCRIPTION

SIGNATURE OF THE CLAIMANT _____ DATE _____

RESPONSIBLE FOR NIHB _____ DATE _____

NIHB DEPARTMENT USE ONLY

AUTHORIZATION NO. _____

SIGNATURE _____ DATE _____

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