First Nations Health Authority
Health through wellness

Mental Health Counselling **Invoice**

SUBMIT TO: Fax: 1.604.658.2833 **Mail:** First Nations Health Benefits
#540 - 757 West Hastings Street
Vancouver, BC V6C 3E6
ATTN: Benefits Assessor

Incomplete Forms will not be processed

Services Provided for the following FNHB Program:

- ❑ Short-Term Crisis Intervention Mental Health Crisis (STCIMHC) Program
- ❑ Indian Residential Schools (IRS) Resolution Health Support Program
- ❑ Missing & Murdered Indigenous Women & Girls Health Services Support (MMIWG HSS) Program

Client Information

CLIENT NAME ______________________

DATE OF BITH (YYYY/MM/DD) ______________________

STATUS NUMBER ______________________

PHONE ______________________

Invoice # ______________________

Make cheque payable to (Payee Name & Address)

PROVIDER NAME ______________________

ADDRESS ______________________

CITY/PROVINCE ______________________ POSTAL CODE ______________________

PHONE ______________________ FAX ______________________

EMAIL ______________________

Invoice Date (YYYY/MM/DD): ______________________

Telehealth Location OR Client (Parent/Guardian) Initials	**Session Date**	**Hour(s) per Session**	**Rate $ ________ X Hours**
			$
			$
			$
			$
			$
	Subtotals		$
Provider GST, Business OR SIN:		**GST (If applicable)**	$
		Invoice Total:	$

Certification

By billing the FNHA Health Benefits, you are certifying that the client was present at each appointment.
I certify that services indicated on the attached FNHA approval letter have been provided in whole or in part and rendered on behalf of the named client.

Provider Signature: ______________________ Date signed (YYYY/MM/DD): ______________________

First Nations Heath Authority Use Only

Finance Use Only

Vendor # ______________ Voucher # ______________

AP Clerk: ______________ Date Entered: ______________