CONFIDENTIAL - SUBSIDY APPLICATION FOR OPIOID AGONIST THERAPY (OAT) CLINIC FEES

First Nations Health Authority
Health through wellness

540–757 W. Hastings St. Vancouver, BC V6C 1A1

INSTRUCTIONS

1. Complete SECTION 1 and ensure client signs and dates SECTION 2 **every month**

2. Scan and send this completed form along with a service invoice to: **oatclinicfees@fnha.ca** or fax to: **604-666-3867**

[SECTION 1] REQUIRED INFORMATION: Please complete every field in this section.

Clinic and prescriber name	Clinic: Prescriber:
Client name and PHN	Name: PHN:
Band name and status number	Band name: Status number:
Client birth date and sex	Birth date: Sex: ☐ M | ☐ F | ☐ Other:
Client location and address	☐ On reserve | ☐ Off reserve | ☐ No Fixed Address Street: City: Postal code:
Treatment	☐ Suboxone | ☐ Methadone | ☐ Other:
Additional treatment information *(describe all services client has received for attached invoice)*	☐ Office visit | ☐ Prescription management | ☐ Social support services ☐ Blood/urine/lab work | ☐ Supportive housing | ☐ Liaison between physicians ☐ Other treatments:

[SECTION 2] CLIENT CONFIRMATION: Client must sign and date EVERY month of service. FNHA will not process invoices that are not signed and dated by the client upon receipt of service.

Month (e.g Jan, Apr, Oct)	Date (dd/mm/yyyy)	Signature

Please contact 1.866.913.0033 (toll free) for any inquiries about completing this form

CONFIDENTIAL - SUBSIDY APPLICATION FOR OPIOID AGONIST THERAPY (OAT) CLINIC FEES

Month (e.g Jan, Apr, Oct)	Date (dd/mm/yyyy)	Signature

Please contact 1.866.913.0033 (toll free) for any inquiries about completing this form