First Nations Health Authority
Health through wellness

HEALTH BENEFITS PROGRAM
Vision Care Prior Approval Form – Eye Examination

Toll Free Line: 1-800-317-7878
Toll Free Fax: 1-888-299-9222

PROVIDER INFORMATION:	**PROVIDER NUMBER:** _____ **TELEPHONE NUMBER:** _____ **FAX NUMBER:** _____ **PROVIDER SIGNATURE**: _____

CLIENT INFORMATION: (MUST BE COMPLETED – INCOMPLETE FORMS WILL BE RETURNED)

NAME OF CLIENT: _____

ADDRESS: _____

CLIENT PHONE NUMBER: _____

10 DIGIT STATUS NUMBER: _____ DOB:_____

PERSONAL HEALTH CARE NUMBER (PHN): _____

DATE OF CLIENT'S LAST EXAMINATION:

REASON FOR EXAMINATION:

First Nation Health Authority reserves the right to deny coverage and/or audit the client's provider.

Once approved a separate Approval/Denial form will be faxed directly to the provider.