



First Nations Health Authority
Health through wellness

540 – 757 West Hastings St
Vancouver, BC
Canada V6C 3E6

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F 1.888.299.9222
www.fnha.ca

PROVIDER REGISTRATION FOR VISION CARE SERVICES

PLEASE CHECK APPLICABLE BOX

OPTOMETRIST

COLLEGE OF OPTOMETRIST OF BC REGISTRATION NUMBER: _____

OPHTHAMOLOGIST

COLLEGE OF PHYSICANS AND SURGEONS OF BC REGISTRATION NUMBER: _____

OPTICIAN

COLLEGE OF OPTICIANS OF BC REGISTRATION NUMBER: _____

GST NUMBER: _____ OR BUSINESS NUMBER : _____

PROVIDER INFORMATION: (PLEASE PRINT CLEARLY)

LAST NAME: _____

FIRST NAME: _____

BUSINESS NAME: _____

BUSINESS ADDRESS: _____

CITY/TOWN: _____ POSTAL CODE _____

BUSINESS PHONE: _____ BUSINESS FAX: _____

EMAIL (OPTIONAL) _____

Cheque payable to (if different from above):

NAME: _____

ADDRESS: _____

CITY/TOWN: _____ POSTAL CODE _____

I HEREBY MAKE APPLICATION TO THE FIRST NATION HEALTH AUTHORITY AS A VISION CARE PROVIDER FOR ELIGIBLE FIRST NATIONS CLIENTS RESIDING IN THE PROVINCE OF BRITISH COLUMBIA.

NAME OF AUTHORIZED PERSON: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATED: _____

TO BE COMPLETED BY FNHA

PROVIDER # _____

APPROVED: _____

DATE: _____

PLEASE FAX THIS REGISTRATION FORM TO 1-888-299-922 OR MAIL TO THE ADDRESS

ABOVE – ATTENTION: HEALTH BENEFITS – PROVIDER REGISTRATION