ʔAKISQNUK FIRST NATION

Health + Wellness

EXTRAORDINARY MEDICAL NEEDS REQUEST FORM

The Extraordinary Medical Needs Policy (P013) provides support for eligible health-related expenses after all other coverage options have been explored. Please complete this form to request support. For full details, refer to the policy on our website at www.akisqnuk.org.

PERSONAL INFORMATION

First Name _____ **Last Name** _____

Phone : _____

E-Mail : _____

Status Card # : _____

☐ I am a Registered ʔAFN Member

☐ I am an Elder Spouse (as defined in Policy P013 Extraordinary Medical Needs Policy)

DESCRIPTION OF MEDICAL NEED

Please describe the service, treatment, or supply you are requesting, including why it is needed and how it will support your health and wellbeing:

_____

_____

_____

BENEFIT COORDINATION

Please indicate which benefits or coverage you have accessed or applied for:

☐ First Nations Health Authority (FNHA) / Pacific Blue Cross

☐ Non-Insured Health Benefits (NIHB)

☐ Extended health benefits (through employer or private insurance)

☐ Income Assistance / Disability benefits

☐ Other (Please specify): _____

☐ Not applicable (please explain): _____

*NOTE: Supporting documentation (e.g., approvals, denials, quotes) is required and **must** be attached for your request to be reviewed.

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COST INFORMATION

Total amount requested (after all other benefits have been applied): _____

PAYMENT INFORMATION

If approved, payment should be made to:

- ☐ Service Provider
- ☐ Applicant (reimbursement)
- ☐ Provincial / Federal Program (e.g. Health Authority, etc.)
- ☐ Other (please specify): _____

Payee details (if applicable):

Name: _____

Phone Number: _____

Mailing Address: _____

_____

DECLARATION

Personal information collected on this form is used solely for the purpose of assessing eligibility under Policy P013 – Extraordinary Medical Needs and is handled in accordance with ʔakisq̓nuk First Nation privacy standards.

I confirm that the information provided is true and complete. I understand that assistance is not guaranteed and is subject to policy criteria and available funding.

Signature : _____

Date : _____

OFFICE USE ONLY

Date Received : _____

Documentation Complete: ☐ Yes ☐ No

Benefit Exhaustion Verified: ☐ Yes ☐ No

Final Decision: ☐ Approved ☐ Denied

Amount Approved: _____

Date of Decision: _____

Contact us:

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www.akisqnuk.org