MEDICAL APPLICATION FORM

NOTE: As per the Tk̓emlúps te Secwépemc Medical/Dental Policy, ALL requests must include a professional's referral, prescription, and original receipts. All reimbursement cheques are mailed via TteS Finance Department — no exceptions. Please allow 10-14 days for processing.

(Reference to Page 6, No. 10 of Medical/Dental Policy)

ALL AREAS HIGHLIGHTED MUST BE COMPLETED

Reimbursement To Client ☐ **No.# of Pages:**

Payment To Provider: ☐ **Assistant Initials:**

DATE:

LEGAL/REGISTERED NAME:

D.O.B. (YY/MM/DD):

STATUS #: **PERSONAL HEALTH #:**

ADDRESS:

PHONE #:

EMAIL:

EXTENDED HEALTH COVERAGE: YES ☐ **NO** ☐

****(FAILURE TO REPORT MAY JEOPARDIZE FUTURE FUNDING) ****

NAME OF EXTENDED HEALTH PROVIDER:

PLAN #: