Revised: February 5, 2020

MEDICAL/DENTAL APPLICATION FORM

As per the Tk'emlúps te Secwépemc Medical/Dental Policy this application must be completed in order to receive funding.

Note: As per the Medical/Dental policy, ALL requests must include a physician / dentist / medical professional's referral and/or prescription and/or original invoices and/or receipts. (Reference to Page 6, No. 10 of Medical/Dental Policy)

Reimbursement: To Client ☐ **Payment To Provider:** ☐ **No.# of Pages:** ______

Mail Out ☐ **Pick up** ☐ **Assistant Initials:** ______

Date: ____________________________

Full Legal/Registered Name: ____

D.O.B.:______________________________ **(dd/mm/year)**

Address: ____**Postal Code:**____________

Phone Number: (_____)______________________ **Cell:** (____)__________________________

Email: ____

If applicable, Name of Parent/Guardian: __________________________________

Status #: 688_________________ **Personal Health #:**________________________

Extended Health/Dental Coverage: **Yes**_____ **No** _____

If yes, attach proof of response & name of Medical/Dental plan provider:

Name:___________________________ **Plan #:**________________________________

Failure to inform TteS of Extended Health Benefits coverage will jeopardize future funding.

_____________________________________ _________________________

Signature of Applicant/Parent/Guardian **Date**