Centre for Addiction and Mental Health
NON-OHIP INSURANCE COVERAGE

Date of Service:	**Unit /Clinic:**	**Provider Seen (if known):**
MRN: **Encounter #:**	**Client/Patient Name (Last, First, Middle):**	**Does the client/patient have provincial health insurance (other than Ontario)?** ☐ **Yes** ☐ **No** **Has the client/patient permanently moved to Ontario?** ☐ **Yes** ☐ **No**
Address in Ontario:		**Home Tel. #:**
Address out of province/out of country:		**Local Tel. #:**

☐ **Provincial Health Insurance (non-OHIP)**
Province: Health Card Number: Expiry date:

☐ **Interim Federal Health Program**
Client ID#: Effective Date: Expiry Date:

☐ **Federal (RCMP/Military)**
Base #: Branch #:

☐ **Private Insurance (including UHIP)**
Name of Insurance Company:

Group/Policy #	Certificate #	ID #
Name of Person Insured:	Date of Birth of Person Insured:	Client/Patient's Relationship to Person Insured:

☐ **Self-Pay: Credit Card**
Card Holder's Name:
Relationship to client/patient:
Telephone#:
Email:

Card Number:
Code on back of the card:
Expiry Date:

I authorized CAMH to charge my credit card for all services received by myself or the client/patient indicated above.

Signature of card holder: _____

OR

☐ **Self-Pay: Send Invoice**
To (Name):
Relationship to client/patient:
Address:

Telephone#:

I authorized CAMH to send an invoice for all services received by myself or for client/patient indicated above.

Signature of payer: _____

☐ **No Coverage provided**

Additional Comments:

_____

To my knowledge the information that I have provided is accurate. I agree to the release of information regarding the services I received at CAMH to my health insurance plan/provider to facilitate the recovery of expenses on my behalf.

_____	_____	_____
Client/Patient or Substitute Decision Maker/Guardian	Signature	Date (mm/dd/yyyy)
_____	_____	_____
Witness	Signature	Date (mm/dd/yyyy)