Ocular Prosthesis Program
Department of Health
PO Box 5100
Fredericton, NB E3B 5G8
Voice Mail Box 1-844-443-3172

APPLICATION FOR OCULAR PROSTHESIS PROGRAM

Personal Information

Last Name:	First Name:

Address: _____
(Number, Street, Apartment, PO Box, Rural Route)

_____
(City, Province, Postal Code)

Home Phone Number: (____) _____ Work Phone Number: (____) _____	Email: _____
Medicare Number: _____	Date of Birth: ____/____/_____ (mm/dd/yyyy)

Declarations

- I do solemnly declare that:
  - I am a resident of New Brunswick, defined as a person lawfully entitled to be or to remain in Canada who makes his or her home, and is ordinarily present, in New Brunswick, but does not include a tourist, transient, or visitor to the Province.
  - In the opinion of a qualified medical practitioner, I require the use of a conventional ocular prosthesis or component. I have included documentation of this with this claim.
  - The amount that I am claiming is not reimbursable under any other federal, provincial or third-party program or private insurance plan.
- I acknowledge and understand that I may be reimbursed for up to 80 per cent of the cost of eligible services as set out in the Program Outline.
- I acknowledge and understand that costs incurred outside of New Brunswick will be eligible only on a case-by-case basis, with prior approval from the Department of Health, and up to the maximum amount prescribed by the Department of Health. I have included a copy of the prior approval with this claim (if applicable). I acknowledge and understand that a claim for out-of-province services must be submitted within 12 months of the date of service or the date of preauthorization to be eligible for reimbursement.
- I have included an original invoice and receipt from an approved clinic which includes the ocularist's name and address, the date the services were rendered, and the name of the referring physician (if applicable).
- I acknowledge and understand that reimbursement for replacement prostheses is limited to once every five years for adults, and once every two years for children and adolescents up to the end of the month of their 19th birthday, but that early replacements may be approved by the Department of Health when accompanied by a referral from an ophthalmologist or a family physician and an explanation from the ocularist of the reasons for the early replacement.
- I acknowledge and understand that payment of my claim is subject to government funding.

I, the applicant, hereby declare that the information given on this application, and in any documents attached, is correct and complete.

Signature of Applicant: _____ Date: _____