



PROTECTED B WHEN COMPLETED.

**Treatment Benefits/Services - Programs of Choice 1-14
Client Reimbursement Claim Form**

File No.

Last Name*		First Name*		Middle Name(s)*	
Mailing Address* (No., Street, Apt. No., PO Box, RR No.)				City/Town/Village*	
Country*		Province/Territory/State*		Postal Code/ZIP*	

Please see reverse for additional information.

Date of Service (yyyy-mm-dd)	Description of Benefit(s)/Service(s) (e.g., eyeglasses, diabetic supplies, physiotherapy, etc.)	Quantity	Amount Claimed	**Pay Provider
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

** Check box if you want Veterans Affairs Canada to pay the provider directly for the benefit(s)/service(s).

The personal information provided on this form is collected under the authority of the *Veterans Health Care Regulations* and/or the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* for the purpose of determining eligibility for, and facilitating the reimbursement of, Treatment Benefits/Services. Providing the information is voluntary, however, failure to complete any part of this form may result in delays.

The personal information collected on this form is protected from unauthorized disclosure by the *Privacy Act*. Name, contact information and information related to Treatment Benefits/Services may be shared with a third party claims processor for reimbursement purposes. Personal information, including Service Health Records, obtained by VAC may be shared with Public Works and Government Services Canada (PWGSC) for the purpose of creating a digital image of the record for use by VAC. By Order in Council 2011-1348, Human Resources and Skills Development Canada (HRSDC) may provide services on behalf of VAC.

The *Privacy Act* also gives individuals a right of access to personal information about themselves under the control of the Department, as well as a right to challenge the accuracy and completeness of their personal information and have it changed as appropriate.

For further information on the above statement, contact the Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, PO Box 7700, Charlottetown, PE, C1A 8M9. Please quote Personal Information Bank Health Care Benefits and Services - VAC PPU 295 and/or Rehabilitation - VAC PPU 300 of the Government of Canada Info Source publication.

I certify that I have received the above Treatment Benefit(s)/Service(s). I certify that, to the best of my knowledge, the information on this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

Note: If this claim is for benefits not related to your disability condition, VAC can only reimburse you for the amount that is not covered by your province or private insurer.

Signature of Client or Client's Representative	Date (yyyy-mm-dd)
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Important Information

- ◆ This claim form is only to be used for reimbursement of treatment benefits and/or services under Programs of Choice 1 to 14.
- ◆ Keep a copy of your completed claim form including a copy of the receipts for your own records.
- ◆ A claim must be submitted within 18 months of the date the benefit or service was received or within 12 months for Rehabilitation benefits/services.
- ◆ If the information regarding your name or address is incorrect, please contact Veterans Affairs Canada at 1-866-522-2122.

If you are requesting reimbursement for:	Use the...
Health Related Travel Benefits	Health Related Travel Claim - Veteran (VAC 752A) reimbursement form
Veterans Independence Program Services	Veterans Independence Program Client Reimbursement Form (VAC930)

Information to be included with your claim form if:	Please remember to include...
You are requesting reimbursement for benefits/services that you have already paid and for which you have not submitted a provincial or private insurance claim.	The original receipt(s) indicating payment in full. Receipts must indicate the name and address of the supplier or provider and a description of the benefits/services received.
You had previously submitted a provincial or private insurance claim for these benefits/services and are requesting reimbursement for the portion not covered by your plan(s).	Copies of all receipts, invoices and prescriptions, along with the original explanation or statement of benefits from the insurer.
You have not paid for the benefits/services and have indicated on the front you want us to pay your provider.	An invoice with the name of the supplier or provider and a description of the benefits/services.
You have a prescription for the benefits/services you received.	A copy of the prescription dated within 12 months of the date of the service.
You are submitting a dental claim.	The original Standard dental claim form.

Please submit your completed claim form to:

National Reimbursement Centre
 PO Box 6700
 Moncton, NB E1C 0T8

Did you know that using your Veterans Affairs Canada Health Identification Card means you can obtain approved benefits and/or services without having to pay out of pocket?