Brokenhead Ojibway Nation (BON)
Health Treatment and Medication Policy

Purpose: Chief & Council have made a decision to assist BON membership financially for non-insured health treatment and medication costs, subject through available BON own source revenue funds that must meet the following criteria to qualify. This is intended to be a policy to benefit registered BON members after other sources of coverage have been exhausted (employee or family member of employee health benefits, FNIH).

Application: Must be completed.

Eligibility: Must be a registered BON member.

Documentation Require: Proof of BON registered membership

Who Qualifies: BON registered members

What is the maximum: $125.00 per month to a max of $1,500.00 per year. BON will not process applications that are for less than twenty dollars ($20.00).

What is covered: a prescription from your doctor that is not covered by FNIH, but, the applicant is required to ensure that their pharmacist/doctor has attempted to obtain the coverage for the prescription

What is not covered: non-prescribed medication, treatment or therapy, over the counter prescriptions, alternative treatment and therapy costs, massage therapy, reflexology

Timeline: Applications must be submitted within a thirty (30) day period

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SCHEDULE A: Listing of Approved Coverage which require a Doctor's prescription

NOTE: This Schedule is subject to revisions as required

1. Eyeglasses
2. Orthopedic (Footwear Lifts, Foot Care)
3. Cataract Surgery
4. Prosthetics
5. Orthodontic (braces, dentures, dental implants)
6. Surgical Stockings
7. Oxygen
8. Infant Formula (Specialized)
9. Chair Lift
10. Skin Care Products (Acne)
11. Equipment (Walk-in Shower, wheel chair, walker)

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Request Application Form

Personal Information of Applicant:

Please Print

NAME: _____

Address: _____

Phone: _____ Cell: _____

_____

Address Postal Code

Purpose of Request: _____

Doctor Recommendation: _____

Cost: _____

Applicant Signature: _____ Date: _____

Note:
If any information is missing the application will be returned and not processed until complete.

Office use only: APPROVED: Yes ◯ No ◯

Date approved: _____

Signature: _____

NOTES: