THE SPINA BIFIDA AND HYDROCEPHALUS ASSOCIATION OF BRITISH COLUMBIA

102 - 15910 Fraser Highway, Suite 228, Surrey BC V4N 0X9
Ph: (604) 878 -7000 Fax: (604) 677-6608

Clinic Claim Form

Name: _____ Phone:_____

Address: _____

City:_____ Postal Code: _____

Name of Person with SB/H: _____ Date of Birth: _____

Description*	Date	Charges
Total Claim:		

*Attach receipts (non-returnable)

I hereby certify that the information given is true to the best of my knowledge.

Signature: _____

Date: _____

Please Note:

1) This fund is designed to cover expenses not reimbursed by any medical plan, extended health benefit plan, or service clubs.
2) This fund will attempt to cover during the calendar year a maximum total of $1700.00 for the following eligible expenses:
   a) "Transportation" portion of scheduled Clinic visits for one child and one parent.
   b) Bowel and bladder management supplies including prescription medications used in the treatment and care of the urinary system

Send completed claim form and receipts to: SBHABC / Clinic Fund
102- 15910 Fraser Highway, Suite 228,
Surrey, BC V4N 0X9

Revised April 30 , 2025