Enhanced Services "Forced Claim" Form

Name of Practice: **Enhanced Service referred to:**	
Patient's CHI Number:	

Provide below an explanation regarding why this claim does not meet all the necessary criteria, yet you feel that it should be paid:
(please include details and dates of all treatment**)**

Name: _____

Signature: _____

Date: _____

Office use only

Authorised by CHP Yes / No

Signature _____ Date: _____