MEDAVIE BLUE CROSS™

EQUIPMENT PURCHASE PRE-AUTHORIZATION REQUEST FORM

SECTION 1 - To be completed by Member/Patient

Section A - Member Information

Member Name: _____ ID Number: _____

Address: _____ Policy Number: _____

_____ Telephone Number: _____

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____

Contact Name: _____ Contact Telephone Number: _____

Is the patient a resident of: ❑ Nursing Facility ❑ Special Care Home ❑ Not Applicable

Has your mailing address changed since your last claim? ☐ Yes ☐ No

If Yes, signature of member is required for validation: _____

Section B - Other Coverage

Do you or any of your dependents have other coverage under any other plan?

☐ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

☐ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ❑ **Individual** ❑ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ❑ Hospital ❑ Travel ❑ Extended Health ❑ Drugs ❑ Vision ❑ Dental ❑ **All**

Section C - Patient (Parent/Guardian) Statement

I authorize the release of any information or records requested in respect of this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

IMPORTANT: Please ensure that all information on this form is completed accurately before signing.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party.
These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature _____ Date _____
(If under 18 years of age the signature of the member is required.)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

IMPORTANT INFORMATION

*** Section 2, on reverse, to be completed by Attending Physician.**
*** Please attach Occupational Therapist Report or Respiratory Therapist Report (if available).**
*** Please include two cost estimates for each item with a cost breakdown.**

Coverage under your Medavie Blue Cross plan is supplemental to coverage available through provincial plans or programs.

The submission of this information does not guarantee payment nor imply approval of a claim or anticipated claim. This information is required to determine if the incurred/anticipated expenses qualify for payment in accordance with Medavie Blue Cross pre-authorization assessment criteria.

If ALL the applicable information below has been provided by the physician, in a letter or prescription, the completion of Section 2 is not required

SECTION 2 - To be completed by the Attending Physician

Patient Name: _____ ID Number: _____

Equipment Required: _____

☐ Manual ☐ Electric ☐ Not Applicable

Equipment currently used by client: _____

Primary Diagnosis: _____ Date of Diagnosis: _____

Secondary Diagnosis: _____

Prognosis (Please check one):
☐ Good ☐ Fair ☐ Poor ☐ Palliative ☐ Terminal

If prognosis is Fair or Poor, please provide details: _____

Expected Duration of Equipment Use (Please check one):
☐ less than 3 months ☐ 3 to 6 months ☐ 6 to 12 months ☐ more than 12 months

For Oxygen Equipment, please include flow rates (if applicable): _____

Other Pertinent Information: _____

PHYSICIAN INFORMATION (to be completed by physician) - PLEASE PRINT

Physician Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

STAMP

*The physician signature is MANDATORY

Signature: _____ **Date:** _____

MEDAVIE BLUE CROSS ADDRESSES

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