MEDAVIE BLUE CROSS™

NURSING / PERSONAL CARE PRE-APPROVAL REQUEST FORM

Coverage for nursing care under your Medavie Blue Cross plan is supplemental to coverage available through provincial plans. If your services are denied by the provincial plan, please obtain a written denial from them and have your prescribing physician complete this form. Please complete this entire form and submit to a Medavie Blue Cross office listed below. If information is missing from the form, it will be returned to the member since incomplete forms cannot be processed.

Please note that the submission of this information does not guarantee payment nor imply approval of a claim or anticipated claim.

This form is to be completed for nursing services rendered in a private residence.

MEMBER'S INFORMATION (to be completed by patient)

Member's Name	ID Number	Policy Number 91174
Patient Name	Date of Birth (DD/MM/YYYY)	Telephone Number

Street Address	City	Province	Postal Code

Contact Name	Daytime Telephone Number

Is the patient a resident of (✓): ◯ Nursing Facility ◯ Special Care Home ◯ Not Applicable

I hereby authorize any health care provider to release to Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life) any medical or other case-related information that may be required by Medavie Blue Cross and/or Blue Cross Life to pre-approve nursing benefits. The requested information is required to determine if the incurred/anticipated expenses qualify for payment in accordance with Medavie Blue Cross and/or Blue Cross Life pre-approval assessment criteria. Medavie Blue Cross and/or Blue Cross Life benefits are supplemental to government-funded hospitals, agencies or providers. Approval is valid only if the policy is active at the time services are rendered.

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 Medavie Blue Cross and/or Blue Cross Life'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 Medavie Blue Cross and/or Blue Cross Life organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber 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 Medavie Blue Cross and/or Blue Cross Life 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 and/or Blue Cross Life to collect, use and disclose my personal information as described above.

Signature(s) of Patient(s): _____
(If under 18 years of age the signature of the subscriber is required.)

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

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

Physician Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

STAMP

PATIENT INFORMATION (to be completed by physician)

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medication: _____

Date of DX

Prognosis (Please check one):
◯ Good (short-term care only) ◯ Fair (potential for improvement) ◯ Poor (no expectation for improvement)
◯ Supervisory / Custodial Care (long-term care, no medical needs) ◯ Palliative (prognosis less than 3 months)

Recommended Duration of Care (Please check one in each column):

Number of **hours** per day:	Frequency of Service:	Duration of Treatment (Please check one):
◯ 1 - 4 ◯ 5 - 8	◯ Daily ◯ Weekly ◯ Biweekly	◯ Less than 3 months ◯ 3 - 6 months ◯ 6 - 12 months
◯ 9 - 12 ◯ 13 - 24	◯ Monthly ◯ Other _____	◯ Other (please indicate) _____

Types of Services Requested (i.e. dressings, personal hygiene):

◯ ADLs ◯ Bloodwork ◯ Dressings
◯ Injections ◯ Medication Administration ◯ Ostomy
◯ Footcare ◯ Vitals

◯ Other (Please Specify)

The following services are NOT ELIGIBLE (unless otherwise stated in your policy):

Meals / Housekeeping
Custodial Care / Respite
Services in hospital/nursing home
Supervision / Monitoring
Shopping / Transportation

Physician Signature: _____ Date: _____

How to Apply For Pre-approved Nursing Care Services

1. Complete the Nursing Care Pre-Approval request form making sure both you and your attending physician sign it.
2. Mail or fax your completed, signed form to the Medavie Blue Cross office nearest you.

Atlantic Provinces	**Quebec**	**Ontario**	**Other Provinces and Territories**
PO Box 220	PO Box 3300 STN B	PO Box 2000 STN A	PO Box 2318 STN Main
Moncton NB E1C 8L3	Montreal QC H3B 4Y5	Etobicoke ON M9 C5P1	Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511
Fax: 1-800-451-0355	Fax: 1-514-286-7643	Fax: 1-800-451-0355	Fax: 1-800-451-0355

3. One of our Case Managers will review your request. Should additional information be required, we will have a representative call you.

   Our Case Manager will inform you what nursing benefits you are eligible for as approved through the pre-approval process. This process normally takes four to seven days. However, in cases where your condition may require immediate services, our Case Manager will approve **eligible** nursing care services up to a maximum of seven days.