MEDAVIE BLUE CROSS™

INTERIM FEDERAL HEALTH PROGRAM

MEDICAL SUPPORT IN TRANSIT PRIOR APPROVAL FORM FOR PRE-DEPARTURE MEDICAL SERVICE PROVIDERS (PART 1)

PROTECTED "B" (WHEN COMPLETED)

1. CLIENT INFORMATION

First Name, Last Name _____

IRCC Immigration Application Number _____

Client ID (UCI) |_|_|_|_|_|_|_|_|_|_|_|_| Date of Birth _____ (Year / Month / Day)

2. PROVIDER INFORMATION

Specialty _____

Name _____

Medavie Blue Cross Provider Number _____

Address _____

City _____ Country _____ Postal or Zip Code _____

Email _____ Fax _____

3. RESETTLEMENT NEEDS ASSESSMENT FORM (IMM 5544) COMPLETE? ❑ Yes ❑ No

4. REQUESTED SERVICES/PRODUCTS

Number	Services or Products requested (see note 19 in the Benefit Grid)	Expected Date of Service (DD / MM / YYYY)	Units of Time (if applicable)	Other/Comments	Amount $ CAD
				TOTAL	

5. CERTIFICATION

I hereby certify that the above statement is true.

Provider's Original Signature/Stamp _____ Date _____

Approved by (IFHP Officer)

Name & signature _____ Date _____

The purpose for the collection of personal information by Medavie Blue Cross will be for the administration of IFHP services and benefits. Medavie Blue Cross will comply with the requirements of the Personal Information Protection and Electronic Documents Act or equivalent provincial law and the Canadian Privacy Act when collecting, using and disclosing personal information. Personal information will not be disclosed to third parties except as authorized or required by law.

Complete Part 1 (administrative) and Part 2 (medical) portions of this form and send to IFHP at IRCC.IFHP-PFSI.IRCC@cic.gc.ca with cc to the IRCC Regional Medical Office in your region. Attach additional documentation if needed

If approved, IFHP will sign and return Part 1 to you. To claim reimbursement, please send a copy of Part 1 signed by IRCC, together with your claim to Medavie Blue Cross at CIC_Inquiry@medavie.bluecross.ca

IMPORTANT: A copy of this form (both Part 1 and Part 2) must be kept on file for audit purposes.

Immigration, Refugees and Citizenship Canada | Immigration, Réfugiés et Citoyenneté Canada

The Interim Federal Health Program is administered by Medavie Blue Cross and is funded by Immigration, Refugees and Citizenship Canada

CIC-041E 02/20

MEDAVIE BLUE CROSS™

INTERIM FEDERAL HEALTH PROGRAM

MEDICAL SUPPORT IN TRANSIT PRIOR APPROVAL FORM FOR PRE-DEPARTURE MEDICAL SERVICE PROVIDERS (PART 2)

PROTECTED "B" (WHEN COMPLETED)

1. CLIENT INFORMATION

First Name, Last Name _____

IME Number _____ UCI Number _____

Anticipated date of Departure _____
Year Month Day

2. OTHER INFORMATION

Medical Diagnoses of Primary Significance (please add ICD-10 code)

_____

_____

_____

Any further clinical details regarding requested services: Medical (MD/Nurse)/Medical Oxygen/Special Seating/Other

_____

_____

_____

Client medically stable for the intended travel itinerary? ❑ Yes ❑ No If No, please estimate when. _____

How would this Medical Support in Transit request improve outcome, and why is it needed over and above standard airline safety procedures? Please also attach summary of travel/aviation medical references used to support decision making in this request (e.g. International Air Transport Association medical guidelines, aviation medical textbook, Aerospace Medical Association guidelines, or similar published professional guidance).

_____

_____

_____

_____

_____

_____

Who is the current caregiver responsible for providing the client's specialized medical needs on a day-to-day basis? (e.g., self, relative, friend, other)

_____

_____

_____

Is the caregiver accompanying the client on the same travel itinerary? ❑ Yes ❑ No

Please ensure a written plan for medical handoff of care at the final destination is in place, in accordance with IOM Guidelines.

_____

Name and Specialty of Provider completing this Medical Support in Transit Request: _____

_____

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