

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: _____

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 understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Signature(s) of Patient(s): _____ Date (DD/MM/YYYY): _____

If under 18 years of age the signature of the subscriber is required.)

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):
<input type="radio"/> 1 - 4 <input type="radio"/> 5 - 8 <input type="radio"/> 9 - 12 <input type="radio"/> 13 - 24	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Biweekly <input type="radio"/> Monthly <input type="radio"/> Other _____	<input type="radio"/> Less than 3 months <input type="radio"/> 3 - 6 months <input type="radio"/> 6 - 12 months <input type="radio"/> 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 Supervision / Monitoring
 Custodial Care / Respite Shopping / Transportation
 Services in hospital/nursing home

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.

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Members Only
 644 Main St, PO Box 220
 Moncton, NB E1C 8L3
 Inquiries: 1-800-677-4511
 Fax: 1-800-451-0355

Ontario Members Only
 PO BOX 2000, 185 The West Mall, Suite 1200
 Etobicoke ON M9C 5P1
 Inquiries: 1-800-677-4511
 Fax: 1-800-451-0355

Quebec Members Only
 1981 McGill College Avenue, Suite 100
 Montreal, QC H3A 3A7
 Inquiries: 1-800-677-4511
 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.