

PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-7643 for residents of Quebec and 1-800-451-0355 for residents of all other provinces.

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Medavie Blue Cross in consultation with independent health care consultants.

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete entire form. Incomplete forms cannot be processed.
- Coverage for surrogacy expenses is intended for reimbursement of expenses incurred by a third party surrogate who cannot be a dependent of the plan member
- Requests for coverage will only be considered for members of benefit plans where the Family Building Benefit has been included as an eligible Extended Health Care benefit.
- Requests for coverage will only be considered for third-party gestational surrogates. Requests for coverage where the surrogate is the biological parent of the child will not be considered.
- Prior Authorization is limited to a specified time period and/or lifetime dollar maximum. Coverage is limited to the maximums and/or frequencies outlined in your employee benefits booklet.
- Prior Authorization coverage is contingent on your continued status as a Medavie Blue Cross cardholder or beneficiary.
- More than one surrogate cannot be eligible at the same time. If a surrogacy agreement has ended with a former surrogate and begun with a new surrogate, a new Prior Authorization Request is required.
- Medical surrogacy expenses are eligible under the Medical Expenses Tax Credit and non-taxable to the claimant. Non-medical surrogacy expenses are considered taxable income to the employee and will be reported on the approved cardholder's T4. If approved, it is in the employee's best interest to submit all non-taxable medical expenses for reimbursement first.
- Only expenses incurred after Prior Authorization is obtained will be eligible for reimbursement.
- Surrogacy expenses must be incurred in Canada only.

1. POLICY INFORMATION

Part A

Plan Member Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Policy Number: _____ ID Number: _____

Part B - Coordination of Benefits

Do you or any dependants have coverage for adoption benefits under any other plan or program? ☐ Yes ☐ No

If Yes, complete the following:

Policy Number: _____ Carrier: _____ Date: _____

(If applicable, please attach Explanation of Benefits from prior carrier with complete form.)

Part C - Authorization

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 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.

I understand that benefits provided under this surrogacy benefit may be considered taxable employment income and that I am responsible for any tax consequences arising from payments made under this benefit. I authorize Medavie Blue Cross to provide information relating to claims made under this benefit to my employer for the purposes of payroll-related taxes and deductions, preparation of tax slips, and other financial and administrative reporting and plan management.

I confirm that the surrogate identified below is a third-party gestational surrogate.

Signature of Member: _____ Date (MM/DD/YYYY): _____

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information on privacy policies at Blue Cross, visit www.medaviebc.ca or call 1-800-667-4511.

2. SURROGATE INFORMATION

Part A

Surrogate Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Date of Birth (MM/DD/YYYY): _____

Do you have valid provincial health coverage in current province of residence? ☐ Yes ☐ No

If yes, indicate provincial health card number: _____

Have you entered into a surrogacy agreement with the plan member or the plan member's spouse? ☐ Yes ☐ No

Date (MM/DD/YYYY): _____

Part B - Surrogate Authorization

I authorize the Plan Member and any health care provider to release to Medavie Blue Cross any personal information about me, including personal health information, relating to a claim made under this surrogacy benefit.

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, may be collected, used, or disclosed to administer the terms of the Plan Member's surrogacy benefit, policy, or group policy. I understand that limited personal information may be collected from and/or released to other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the Plan Member and other third parties when required to administer and manage this surrogacy benefit. 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 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 from providing requested coverage or benefits to the Plan Member. 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. I confirm that the Surrogate Information provided on this form is true and accurate.

Signature of Surrogate: _____ Date (MM/DD/YYYY): _____