

**PLEASE PRINT ALL INFORMATION.
PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS FOR ALL SERVICES RENDERED.
FOR ADDRESSES OR INQUIRY NUMBERS PLEASE SEE REVERSE.**

SECTION 1 - To be completed and signed by the patient (parent / guardian).

Subscriber Name _____	Identification No. _____
Address _____	Policy No. _____
	Employer Name _____
Patient Name _____	Patient Age _____ Relationship to Subscriber _____

COORDINATION OF BENEFIT INFORMATION

Do you or any of your dependents have other coverage under any other plan? Yes No **If Yes, please complete the following:**

Name of person insured under other plan _____ Date of Birth _____ Effective Date of Coverage _____

Insurance Company Name _____ Identification No. _____ Policy No. _____

Family Contract Single Contract Type of Coverage: Hospital Drugs EHB Vision Dental

This is to certify that the following is a true and correct statement of expense, that the nurse(s) / personal care attendant(s) listed herein is (are) not related to me or any member of my family and does (do) not reside in my household. 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 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 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 of Patient: _____ Date: _____
(if under 18 years of age, the signature of subscriber/parent/legal guardian 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.

*not applicable in Ontario or Quebec

SECTION 2 - To be completed by the attending physician.

<p>DIAGNOSIS INFORMATION</p> <p>Primary Diagnosis _____</p> <p>_____</p> <p>_____</p> <p>Other Pertinent Diagnoses _____</p> <p>_____</p> <p>_____</p>	<p>Description of Prescribed Medical Services _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>CERTIFICATE OF ATTENDING PHYSICIAN</p> <p>I hereby certify that I prescribed private duty nursing / personal care service for the above named patient, due to the seriousness of the patient's illness for the period</p> <p>from _____ to _____ .</p> <p>_____ M.D.</p> <p style="text-align: center;">Signature</p>	<p>PLEASE PRINT</p> <p>Physician Name _____</p> <p>Address _____</p> <p>_____</p> <p>Date _____</p>
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SECTION 3 ON REVERSE PAGE TO BE COMPLETED BY NURSING/PERSONAL CARE PROVIDER

