

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 an Medavie Blue Cross office listed below. If information is missing from the form, it will be returned to the subscriber as incomplete forms cannot be processed.

PATIENT INFORMATION (to be completed by patient)

Subscriber Name		Identification Number		Policy Number	
Patient Name		Date of Birth (YY/MM/DD)		Telephone Number ()	
Street Address		City	Province		Postal Code
Contact Name				Daytime # ()	

I hereby authorize any health care provider to release to Medavie Blue Cross, any medical or other case related information that may be required by Medavie Blue Cross to pre-approve nursing benefits. **Please note that the submission of this information does not guarantee payment nor imply approval of a claim or anticipated claim.** The requested information is required to determine if the incurred/anticipated expenses qualify for payment in accordance with Medavie Blue Cross pre-approval assessment criteria. Medavie Blue Cross benefits are supplemental to government-funded hospitals, agencies or providers. Approval is valid only if 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 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(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, visit www.medavie.bluecross.ca or call 1-800-667-4511.

*not applicable in Ontario or Quebec

PHYSICIAN INFORMATION (to be completed by physician)

Physician Name		Telephone Number ()		Fax Number ()	
Street Address		City	Province		Postal Code

PATIENT INFORMATION (to be completed by physician)

Diagnosis: _____		Date of DX
Prognosis (Please check one): <input type="checkbox"/> Good (short term care only) <input type="checkbox"/> Fair (potential for improvement) <input type="checkbox"/> Poor (no expectation for improvement) <input type="checkbox"/> Supervisory / Custodial Care (long term care, no medical needs) <input type="checkbox"/> Palliative (prognosis less than 3 months)		
Recommended Duration of Care (Please check one in each column):		
Number of hours per day:	Number of days per week:	<input type="checkbox"/> 0 - 6 weeks <input type="checkbox"/> 0 - 3 months <input type="checkbox"/> 7 - 12 weeks <input type="checkbox"/> 4 - 12 months <input type="checkbox"/> Other (Please Indicate) _____
Types of Services Requested (i.e. dressings, personal hygiene): Eligible: <input type="checkbox"/> ADLs <input type="checkbox"/> Bloodwork <input type="checkbox"/> Dressings <input type="checkbox"/> Injections <input type="checkbox"/> Ostomy <input type="checkbox"/> Footcare <input type="checkbox"/> Medication Administration <input type="checkbox"/> Other (Please Specify) _____		Ineligible: <input type="checkbox"/> Meals / Housekeeping <input type="checkbox"/> Supervision / Monitoring <input type="checkbox"/> Custodial Care
Physician Signature: _____		Date: _____

How to Apply For Pre-approved Nursing Care Services

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

New Brunswick and Prince Edward Island Subscribers:
 Medavie Blue Cross
 644 Main St PO Box 220
 Moncton NB E1C 8L3
 Inquiries: 1-800-667-4511
 Fax: 1-800-451-0355

Nova Scotia Subscribers Only:
 Medavie Blue Cross
 7 Spectacle Lake Dr Dartmouth
 PO Box 2200 Halifax NS B3J 3C6
 Inquiries: 1-800-667-4511
 Fax: 1-800-451-0355

Newfoundland Subscribers Only:
 Medavie Blue Cross
 66 Kenmount Road, Suite 102
 Board of Trade Building
 St. John's NL A1B 3V7
 Inquiries: 1-800-667-4511
 Fax: 1-800-451-0355

Ontario Subscribers Only:
 Medavie Blue Cross
 185 The West Mall Suite 1200
 Etobicoke ON M9C 5 P1
 Inquiries: 1-800-355-9133
 Fax: 1-800-866-1166

- 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.