Chambers Plan
Employee Benefits

JG101-CH

Private Duty Nursing Pre-Authorization

This pre-authorization form must be completed, in full, prior to submitting a claim for Private Duty Nursing.

Any cost for completion of this form is the expense of the employee. Forward this completed form, along with a private duty nursing cost estimate to:

Chambers of Commerce Group Insurance Plan
1051 King Edward Street
Winnipeg, MB R3H 0R4

This request for pre-authorization, and all relevant information provided, will be reviewed upon receipt. Additional diagnostic or clinical information may be requested.

A pre-authorization statement will then be issued indicating approval or denial of expenses.

EMPLOYEE

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____
Last First

Address _____
Include apartment number, street address, city, province and postal code

PATIENT

Patient Name _____ Date of Birth (YYYY/MM/DD) _____
Last First

I hereby certify that the information provided in connection with this pre-authorization is true, accurate and complete. I hereby authorize any physician, provider or insurance company to give Chambers of Commerce Group Insurance Plan any information as required in connection with this pre-authorization request. A photocopy of this authorization shall be as valid as the original.

Signature of Patient _____ Date (YYYY/MM/DD) _____
(if under 16, signature of Employee is required)

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

CONTINUED

MEDICAL DOCTOR (PLEASE PRINT)

Name _____

Address _____

Include suite number, street address, city, province and postal code and telephone number

Diagnosis (please specify the medical condition and the date of onset) _____

Prognosis _____

Please indicate the level of care required for this patient. (RN, RNA, or other) _____

Please indicate where these services are being provided. (home, hospital or other) _____

Please indicate expected duration of care. _____

How many hours of private duty nursing are recommended per day, and how many days per week? _____

Please provide details of all current medications. (name, administration technique and frequency required) _____

Please advise exact duties to be provided by the caregiver. _____

Could someone with lesser qualifications administer this care? _____

Additional comments _____

Signature of Medical Doctor _____ Date (YYYY/MM/DD) _____