Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6
Fax: 418-838-2134
1-877-838-2134

GROUP INSURANCE - HEALTH CLAIMS

PRIOR AUTHORIZATION REQUEST

Please read the instructions on the back of this form and complete the entire form. If any information is missing, the form will be returned to the member.

A - PATIENT'S IDENTIFICATION — TO BE COMPLETED BY THE MEMBER.

Patient's last name and first name	Relationship with member	Date of birth of patient
	☐ Member ☐ Spouse ☐ Dependent child	YYYY MM DD

Member's last name and first name	Contract no.	Certificate no.

No., street, apt. | City | Province | Postal code

Telephone nos: Home: ( ) - Office: ( ) - Extension:

Since the response to this request includes confidential information, please indicate how you would like to be informed of the decision:
☐ By fax: ( ) - ☐ By mail (The response to your request will be sent to the address indicated in this section.)

PROVINCIAL PLAN — **Has a request for reimbursement been submitted under your provincial plan?**

☐ **Yes** - Please provide a copy of the notice of approval or refusal.
☐ **Copy attached to this form.**

☐ **No** - Please explain: _____

PATIENT SUPPORT PROGRAM — **Is the patient enrolled in a patient support program?** ☐ **Yes** ☐ **No**

If so - Program name: _____

Contact person: _____

Telephone no.: ( ) - Extension:

B - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary use the personal information it may have about me in existing files that are now closed. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of member _____ **Date** _____

Last name and first name of parent/legal guardian (if necessary) _____

Signature of patient or parent/legal guardian (if necessary): **Date:**

C - ATTENDING PHYSICIAN'S SECTION — TO BE COMPLETED BY THE ATTENDING PHYSICIAN.

Physician's last name and first name (PLEASE PRINT)	License no.	Speciality

No., street, office | City | Province | Postal code

Telephone no.: ( ) - Fax no.: ( ) -

Signature of physician: **Date:**

Drug name	Formulation	Strength	Dosage	Patient's weight	Scheduled duration of treatment

The patient is receiving or will receive the treatment in a hospital setting: ☐ Yes ☐ No

Diagnosis - Please explain:

C - ATTENDING PHYSICIAN'S SECTION (CONTINUED)

Prior medication or treatment

Has the patient ever used medication or received treatment for this condition? ☐ Yes ☐ No

If not, please explain: _____

If so, please list the medication or treatment already used for this disease:

Medication or treatment name	Dose	Treatment period	Reaction to treatment

Prescription renewal

Please provide objective evidence of efficacy: _____

The drug may be eligible for reimbursement only if it meets the insurer's criteria, if it is not administered in a hospital setting and if it is not covered under a provincial drug insurance plan or a government program.

If you are enrolled in a provincial drug insurance plan, please submit your claim to this plan first since it may cover this drug. If your claim is refused by your provincial drug insurance plan, please send us a copy of the notice of refusal and the form completed by your physician so that we can analyze your file.

INSTRUCTIONS - HOW TO COMPLETE AND RETURN THIS FORM

1. Complete sections A and B.
2. Ask your physician to complete section C. The member is responsible for assuming any costs incurred to complete this form or to obtain additional information.
3. To obtain a reimbursement **once the drug has been approved**, please use your Express Scripts Canada card at the pharmacy or submit your original receipts by mail. Eligible drugs must be dispensed by a pharmacist or a physician, if there is no pharmacist.
4. Send form:
   - by fax: Desjardins Financial Security Life Assurance Company
     Group Insurance, Health Claims,
     418-838-2134 or 1-877-838-2134 (toll free).
   - by mail: Desjardins Financial Security Life Assurance Company
     Group Insurance, Health Claims
     C. P. 3950, Lévis (Québec) G6V 8C6

Under its prior authorization program, DFS approves the payment of certain claims that meet criteria established jointly with healthcare consultants. If the information on your form is complete, your request will normally be processed within 5 business days. When the request form is received, it will be assessed in the strictest confidence. In some situations, additional diagnostic or clinical information may be required.

If the treatment continues beyond the authorized period, you will be asked to submit a new request form and provide information that justifies the extension of treatment. If you have an Express Scripts Canada card, your pharmacist will be advised that the authorization period is coming to an end.

The insurance must be in force and the patient still covered at the date expenses are incurred. This prior authorization is subject to change if, at the time expenses are incurred, the contract has been modified.

When a prior authorization is rejected, it means that DFS refuses to pay for a product. It is not an indication that DFS is challenging the opinion of the physician.
If you have any questions, please contact our Customer Contact Centre.

PRINT NEW REQUEST