Public Service Health Care Plan
Durable Equipment Application Form

PROTECTED "B" WHEN COMPLETED

THIS IS A: ☐ Claim for benefits ☐ Pretreatment/estimate

PART 1 – Instructions

Please use this form to submit your application for durable equipment to Canada Life. This form is only required for the following types of durable equipment: patient lifters, wheelchairs, hospital beds and therapeutic mattresses.

1. Complete parts 2 to 6 in full and have your attending physician or nurse practitioner complete parts 7 to 12.
2. Attach receipts/quotes for all services and retain copies for your files as originals will not be returned.
3. Send to Canada Life. See part 13.
4. Please apply for coverage through the appropriate provincial/territorial health program before submitting this application to Canada Life (if applicable).

Please note that physician's fees for providing medical information are not covered under the Public Service Health Care Plan (PSHCP).

All forms under the Public Service Health Care Plan (PSHCP) must be submitted through the plan member. We may disclose personal information about claims with your employer, your service provider, and/or a person acting on your behalf when necessary to confirm eligibility and to mutually manage your assessment.

PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your Public Service Health Care Plan (PSHCP) benefit card, the Canada Life PSHCP Member Services website or Part 13 for our contact information.

Plan name: **Public Service Health Care Plan**

Plan number

Plan member certificate number

Plan member name

First name

Last name

Plan member address

Number and street

City or town

Province/Territory/State

Postal/Zip Code

Country

Date of birth Day Month Year

PART 3 – Patient information

Patient name		Patient's relationship to plan member			Patient's date of birth			If dependant child is between 21 and 25 years old, are they a full-time student?	
First name	Last name	Self	Spouse or common-law partner	Dependant child	Day	Month	Year	Yes	No
		☐	☐	☐				☐	☐

PART 4 – Coordination of benefits - Complete this section to indicate whether you or any member of your family have benefit coverage under any other plan.

1. Is this patient entitled to any other health insurance plan benefits? ☐ Yes ☐ No
   If yes, please answer the questions below.
2. Who does the other insurance belong to? ☐ Self ☐ Spouse or common-law partner ☐ Dependant child
   First name _____ Last name _____
3. If the other insurance plan belongs to your spouse or common-law partner and the claimant is a dependant child, please provide your spouse or common-law partner's date of birth. Day Month
4. Is the other insurance also with Canada Life? ☐ Yes ☐ No
   If yes, please provide: Canada Life plan number _____ Certificate number _____
   Other insurance plan member's signature of authorization: X _____

* If other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach to this claim the Explanation of Benefits (EOB) provided by the other insurer. An EOB is required even if no benefits were paid by other insurance.

** We assess claims using the information you provided during Positive Enrolment, any discrepancies may delay our assessment of your claim.

PART 5 – Privacy

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your application and administering the group benefits plan. Please refer to the PSHCP Privacy Statement (canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html) for further information on how your privacy is protected.

Where there is a difference between the Privacy Act (//laws-lois.justice.gc.ca/eng/acts/P-21/) and the PSHCP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to canadalife.com.

PART 6 – Confirmation, authorization and signature

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pshcp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP Privacy Statement.

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

Plan member signature X _____ **Date** Day | Month | Year

PART 7 – Type of durable equipment prescribed

1. Please indicate the type of equipment that is being prescribed for your patient.
   ☐ Patient lifter ☐ Wheelchair ☐ Hospital bed ☐ Therapeutic mattress
2. Please outline the patient's medical diagnosis and the reasons that this equipment is medically necessary.

   _____
3. Please fill out the appropriate section(s) below that apply to the type of equipment being prescribed.

PART 8 – Request for patient lifter

1. Please describe the type of lifter and its intended use.

   _____
2. Please confirm where this equipment will be used (e.g., in the patient's home, for the vehicle or other residence, etc.).

   _____

PART 9 – Request for wheelchair

1. Please describe the type of wheelchair (e.g., manual, electric, scooter, geriatric, etc.) and its intended use.

   _____
2. Please provide details of the specific limitations of the patient's medical condition in terms of upper arm strength, range of motion, and additional clinical details that may support the need for the specific equipment being prescribed.

   _____
3. If the equipment now being prescribed is a replacement for a previous wheelchair, please indicate the date of the previous wheelchair purchased, the type of chair previously purchased and the reasons that a new wheelchair is required.

   _____

PART 10 – Request for hospital bed

1. Please describe the type of hospital bed (manual or electric) and its intended use. Please note that a commercially available adjustable bed will not be considered in lieu of a hospital bed.

   _____
2. Please confirm where this equipment will be used (e.g., in the patient's home, other residence, etc.).

   _____
3. Is the patient primarily immobilized? _____
4. Is the hospital bed required on a short-term or long-term basis? _____
5. If an electric hospital bed has been prescribed, please outline how the patient's medical condition precludes the use of a manual crank bed.

   _____

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PART 11 – Request for therapeutic mattress

1. Please describe the therapeutic mattress being prescribed and its intended use.

2. Please confirm where this equipment will be used (e.g., in the patient's home, other residence, etc.).

PART 12 – Attending physician's or nurse practitioner's confirmation and signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

Physician or nurse practitioner's name

Name | Phone number

Physician or nurse practitioner's address

Number and street | City or town | Province/Territory/State | Postal/Zip Code

Signature X _____ **Date** Day | Month | Year

PART 13 – Submitting your application

Please send the completed form to:

ONLINE

canadalife.com/pshcp

Sign into your Member Services account to submit claims or estimates.

MAIL

Winnipeg Benefit Payments
PO Box 99451 Stn Main
Winnipeg MB R3C 1E6

Questions? Call Canada Life:

Call toll free 1-855-415-4414
Monday to Friday from 8 am to 5 pm, your local time.

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

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