Public Service Health Care Plan

Positive Airway Pressure Machine Assessment 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 a positive airway pressure machine to Canada Life.

1. Complete parts 2 to 6 in full and have your attending physician or nurse practitioner complete parts 7 to 10.
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 11.
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 11 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.

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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 – Machine details

1. Is this an initial machine? ☐ Yes ☐ No
2. If this is a replacement machine, please answer a, b and c below.
   a. What was the patient's previous device?
      ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV (Adaptive Servo Ventilation ☐ Dental sleep apnea appliance
   b. When did the patient get their previous device? Month | Year
   c. What is the patient's new device?
      ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV (Adaptive Servo Ventilation ☐ Dental sleep apnea appliance
   d. Please advise why the patient needs a new machine or why they are getting a different type of machine (e.g., BPAP instead of a CPAP).
      _____

PART 8 – Request for initial PAP device/dental sleep apnea appliance

1. What type of device are you prescribing your patient?
   ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV (Adaptive Servo Ventilation) ☐ Dental sleep apnea appliance
2. What type of sleep study did the patient participate in?
   ☐ Level 1 (lab/clinic) ☐ Level 3 (home study) ☐ Other, please specify: _____
   Please attach a copy of the sleep study diagnostic report (including date of sleep study) and any titration.
3. Which diagnosis does the sleep study confirm? (check one)
   ☐ Mild OSA ☐ Mod/Severe OSA ☐ Other, please specify: _____
4. For mild OSA, please advise if patient:
   ☐ has other medical conditions/comorbidities. Please specify: _____
   ☐ works in a "safety-sensitive" profession/occupation. Please specify: _____

PART 9 – Request for BPAP/VPAP/ASV/dental sleep apnea appliance only (please provide medical information and test results to support the checked items).

Please check all that apply and provide medical information and test results to support the checked items:

- ☐ Nocturnal 02 saturation <88% on CPAP of 15 cm H20 or greater
- ☐ Nocturnal hypercapnia on CPAP 15 cm H20 or greater
- ☐ Apnea/hypopnea index of >10 on CPAP 15 cm H20 or greater
- ☐ Obesity hypoventilation syndrome
- ☐ Opioid induced sleep disordered breathing
- ☐ Cheyne-stokes respirations
- ☐ Requires pressures of ≥ 15 cm H20
- ☐ Unable to tolerate any level of CPAP despite adequate trial
- ☐ Remains symptomatic despite adequate CPAP trial (Epworth score: ____)
- ☐ Chronic hypercapnic respiratory failure
- ☐ Central/mixed sleep apnea
- ☐ Unable to tolerate CPAP/APAP/BPAP
- ☐ Neuromuscular disease or chest wall disease affecting respiration. Please specify: _____
- ☐ Other, please specify: _____

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PART 10 – 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 11 – 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

Clear