

PART 1 – Instructions

Please use this form to submit your application for coverage of prescribed vitamins or minerals to Canada Life.

1. Complete parts 2 to 7 in full and have your attending physician or nurse practitioner complete parts 8 to 9.
2. Please apply for coverage through the appropriate provincial/territorial health program before submitting this application to Canada Life (if applicable).
3. Send to Canada Life. See part 10.

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 Service website or Part 10 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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

1. Is the patient currently on or previously been on this vitamin or mineral? Yes No

If "Yes", please answer the questions below.

a. Indicate the date you started this medication. Day: _____ Month: _____ Year: _____

b. Coverage provided by: _____
(if coverage was not provided by Canada Life, please provide a pharmacy print-out showing purchase of this drug)

PART 4 – Coordination of benefits - Complete this section to indicate whether the patient has benefit coverage under any other plan.

1. Does the patient have prescription drug coverage under any other benefit plan? Yes No

If "Yes", please answer the questions below.

2. Name of the insurance company? _____

3. Is the other plan with Canada Life? Yes No

If "Yes", please provide: Canada Life plan number _____ Certificate number _____

Name of plan member _____ Relationship to patient _____

Other insurance plan member's signature of authorization: X _____

Provide details and attach documentation of your other insurance company's acceptance or denial of this prescribed vitamin or mineral:

PART 5 – Provincial or territorial coverage

1. Does the patient have coverage under a provincial or territorial program or from any other source? Yes No
 If "Yes", name of program or other source: _____
 Provide details and attach documentation of the province or territory's acceptance or denial of this prescribed vitamin or mineral:

PART 6 – Privacy

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to canadalife.com or write to Canada Life's Chief Compliance Officer. Please refer to the [PSHCP Privacy Statement \(canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html\)](http://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 \(//laws-lois.justice.gc.ca/eng/acts/P-21/\)](http://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.

PART 7 – 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 acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

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

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

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. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan member signature X _____ Date Day Month Year

PART 8 – Patient medical information - To be completed by the attending physician or nurse practitioner.

Attach extra information if necessary. **GENETIC TEST RESULTS ARE NOT REQUIRED**

- Name of vitamin or mineral prescribed: _____ DIN: _____
NOTE: In order for coverage to be applied, DIN must be provided.
- Prescribed dosage and regimen: _____
- What is the anticipated duration of treatment with this prescribed drug?
 Start date Day Month Year End date Day Month Year
- Where will treatment be administered? Home Physician's office Private clinic Hospital in-patient Hospital out-patient
- Prescription drug and treatment history – **must be completed for every request.**

Prescription drug(s) and treatment(s) past and present	Dosing regimen	Start date (mmm-dd-yyyy)	End date (mmm-dd-yyyy)	Clinical results/outcome
				<input type="checkbox"/> Failure <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Clinical details: _____ _____
				<input type="checkbox"/> Failure <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Clinical details: _____ _____

PART 8 – Patient medical information, continued - To be completed by the attending physician or nurse practitioner.

Vitamins or minerals coverage requested

Is the vitamin or mineral being prescribed for the treatment of a chronic disease, in accordance with customary practice of medicine? Yes No
 Diagnosis: _____

Is this treatment proven to have therapeutic value in the treatment of this condition? Yes No
 If "Yes", please explain: _____

Are any alternative treatments available to the patient? Yes No

PART 9 – Attending physician's or nurse practitioner's information, 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 and designation _____

Specialty _____ Registration number _____

Physician or nurse practitioner's address

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

Telephone number (including area code) _____ Fax number (including area code) _____


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

PART 10 – Submitting your application

Please send the completed form to:

MAIL Drug Claims Management The Canada Life Assurance Company PO Box 6000 Winnipeg MB R3C 3A5	FAX Drug Claims Management 1-204-946-7664	EMAIL cldrug.services@canadalife.com
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Questions?
Call toll free 1-855-415-4414
Monday to Friday from 8 am to 5 pm, your local time or sign in to your account on the Canada Life PSHCP Member Services website at canadalife.com/pshcp and go to the Contact Us page.

 **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