

Authorization Form for the Services of Private Duty Nursing

To the Patient: The details requested below are mandatory in order for Western Financial Group Insurance Solutions to determine our liability with respect to this request. For prior approval, please forward this form to the address indicated below. A response letter outlining our liability will be forwarded to the patient promptly. Our decision is not intended to interfere with or reflect upon the course of treatment recommended by your doctor. Failure to request pre-approval may result in a denial of your claim.

TotalGUARD

Plan Member/Employee Statement

Plan Member/Employee		Patient's Name	Date of Birth (yy/mm/dd)
Address			
Plan Member/Employee Telephone Number	Group Policy Number	Certificate Number	
Do you have any other coverage that would cover these services? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide insurance company name:	
If other coverage is Western Financial Group Insurance Solutions, indicate group policy and certificate number:			

Must be Completed in Full by Physician

I, as the attending physician, hereby authorize services for Nursing Care for the above named patient.

Patient diagnosis (please be specific):

Special care and treatment to be rendered (indicate duties to be performed, including any complications or extenuating circumstances, special equipment that needs to be monitored, medications to be administered and whether they are being administered on a regular or a PRN basis, orally or by injection, intramuscular or subcutaneous). PLEASE BE SPECIFIC.

Starting date of care:

Expected duration of need for these services: _____ Week(s) _____ Month(s) _____ Year(s)

Number of hours PER DAY that these services are required:

Number of days per week that services are required:

Are these services required in the patient's home? Yes No

Are these services being requested in addition to those being provided under Government funded programs (i.e. Ontario-Home Care)? Yes No

If yes, attach a letter outlining what services are being provided. If no, please specify reason. _____

Hours per day _____ Level of Care (RN, RPN) _____ Name of Agency _____

If Nursing Care is being requested, please provide reasons why someone with lesser qualifications could not accommodate these needs.

Are these services required due to a work related accident? Yes No

Are these services required due to a motor vehicle accident? Yes No

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our web site: www.westernfgis.ca

Physician's Signature

Date

Physician's Name (please print)

Physician's Phone Number



Complete and send to:

TotalGUARD, Western Financial Group Insurance Solutions
777 Portage Avenue, Winnipeg, MB R3G 0N3
Toll Free: 1-800-665-8990

Western Financial Group (Network) Inc.
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