beneva

Application for Assessment
Prior Authorization Drug
Type-2 Diabetes

Instructions

Complete the form

1. The plan member completes Section A.
2. The prescriber completes Section B.

Submit the form

1. Through the Customer Centre
2. By fax: 1 855 453-3942
3. By mail: 2525, boul. Laurier, C.P. 10500, Québec (Québec) G1V 4H6

Customer service

1. The Customer Centre's *Contact Us* section
2. 1 800 380-2588

A – Plan member's statement

1. Plan member's information

Certificate no. _____ Policy no. _____ Email _____

Last name _____ First name _____

Address _____

City _____ Province _____ Postal code _____ Telephone _____

2. Patient information

Last name _____ First name _____ Date of birth _____

Relationship to the plan member: ☐ Spouse ☐ Dependent child Child's status: ☐ Student ☐ Disabled child

Educational institution _____

3. Other prescription drug insurance held by the patient

Private plan Is the patient covered under another private prescription drug insurance plan? ☐ Yes ☐ No

If so — Name of the insurer: _____

Status of the claim: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

Provincial plan Is the patient covered for the requested prescription drug by a provincial plan? ☐ Yes ☐ No

If so — Status of the application: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

If the patient is covered under another prescription drug insurance plan, please attach the acceptance or denial documents, if applicable.

4. Protection of personal information

Protecting your personal information is very important to Beneva. To find out more about our procedures, please read our *Privacy Statement* at www.beneva.ca.

5. Statement

I authorize any healthcare professional and intervening party in the field of health, rehabilitation professional, healthcare service provider, public or private health or social services institution, private, public or parapublic agency, insurance or reinsurance company, employer or former employer, policyholder, information agency as well as any person or entity likely to be holding personal information about me, such as medical records, to communicate it to Beneva Inc. when it is required for administering my claims. I acknowledge having obtained consent from any other people included in this claim for Beneva Inc. to gather, use and communicate their personal information. I declare that the information provided on this form is true and complete.

Signature _____ Date _____

B – Prescriber's statement

1. Prescriber's information

Last name _____ First name _____ Telephone _____

Licence No.: _____ Specialization _____ Fax _____

2. Drug prescribed

Drug name _____ Treatment start date _____ Treatment end date _____

Pharmaceutical form _____ Amount _____ Prescribed dose _____ Frequency of dose _____

3. Diagnosis

☐ Confirmed Type-2 Diabetes ☐ Other. Specify: _____ Onset of symptoms: _____

4. Summary of previous tests

Prescription drug	Dosage	Reason for stoppage	Duration of treatment
Name: _____		☐ Inefficacy ☐ Intolerance	Start: _____ End: _____
Name: _____		☐ Inefficacy ☐ Intolerance	Start: _____ End: _____

5. Additional information

6. Statement

I certify that the information provided above is accurate.

Signature _____ Date _____