



## PRIVATE DUTY NURSING PRE-AUTHORIZATION

This pre-authorization form must be completed, in full, prior to submitting a claim for Private Duty Nursing.

**Any cost for completion of this form is the expense of the covered individual.** Forward this completed form, along with a private duty nursing cost estimate to:

ContinuYou National Service Centre  
1051 King Edward St  
Winnipeg MB R3H 0R4

This request for pre-authorization, and all relevant information provided, will be reviewed upon receipt. Additional diagnostic or clinical information may be requested.

A pre-authorization statement will then be issued indicating approval or denial of expenses.

### Covered Individual

Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Covered Individual \_\_\_\_\_  
LAST FIRST

Address \_\_\_\_\_  
INCLUDE APARTMENT NUMBER, STREET ADDRESS, CITY, PROVINCE AND POSTAL CODE

### Patient

Patient Name \_\_\_\_\_ Date of Birth (YYYY/MM/DD) \_\_\_\_\_  
LAST FIRST

I hereby certify that the information provided in connection with this pre-authorization is true, accurate and complete. I hereby authorize any physician, provider or insurance company to give Johnston Group Inc. and The Co-operators any information as required in connection with this pre-authorization request. A photocopy of this authorization shall be as valid as the original.

Signature of Patient \_\_\_\_\_ Date (YYYY/MM/DD) \_\_\_\_\_  
(IF UNDER 16, SIGNATURE OF EMPLOYEE IS REQUIRED)

### Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I authorize Johnston Group and The Co-operators to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Covered Individual \_\_\_\_\_ Date \_\_\_\_\_

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**Medical Doctor (Please Print)**

Name \_\_\_\_\_

Address \_\_\_\_\_

INCLUDE SUITE NUMBER, STREET ADDRESS, CITY, PROVINCE AND POSTAL CODE AND TELEPHONE NUMBER

Diagnosis (please specify the medical condition and the date of onset) \_\_\_\_\_

\_\_\_\_\_

Prognosis \_\_\_\_\_

\_\_\_\_\_

Please indicate the level of care required for this patient. (RN, RNA, or other) \_\_\_\_\_

\_\_\_\_\_

Please indicate where these services are being provided. (home, hospital or other) \_\_\_\_\_

\_\_\_\_\_

Please indicate expected duration of care. \_\_\_\_\_

\_\_\_\_\_

How many hours of private duty nursing are recommended per day, and how many days per week? \_\_\_\_\_

\_\_\_\_\_

Please provide details of all current medications. (name, administration technique and frequency required) \_\_\_\_\_

\_\_\_\_\_

Please advise exact duties to be provided by the caregiver. \_\_\_\_\_

\_\_\_\_\_

Could someone with lesser qualifications administer this care? \_\_\_\_\_

\_\_\_\_\_

Additional comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Medical Doctor \_\_\_\_\_ Date (YYYY/MM/DD) \_\_\_\_\_