Retiree Plans

Johnston group

JG101-JG

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:

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

Firm # _____ Certificate # _____

Covered Individual's Name _____
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. any information as required in connection with this pre-authorization request. Any copy of this authorization shall be as valid as the original.

Signature of Patient _____ Date (YYYY/MM/DD) _____
(IF UNDER 16, SIGNATURE OF COVERED INDIVIDUAL 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. I acknowledge that no benefits will be payable until the insurer approves this application. I authorize Co-operators, Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. 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. I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.johnstongroup.ca. Any copy of this authorization shall be as valid as the original.

Signature of Covered Individual _____ Date _____

CONTINUED

NATIONAL SERVICE CENTRE
1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1-800-893-7587

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) _____