



OTIP RAEO

OTIP Health Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9
1.866.783.6847
www.otipservices.com

Prescription Drug Special Reimbursement Request Form

PATIENT INFORMATION (Please Print)

| | | | | | |
|----------------------------|--|-----------------------------|--|-----------------------|--|
| Plan Member Name | | Plan Number | | Identification Number | |
| Patient Name | | Relationship to Plan Member | | Street Address | |
| City | | Province | | Postal Code | |
| | | | | Telephone Number () | |
| Date of Birth (mm/dd/yyyy) | | | | | |

PHYSICIAN INFORMATION (Please Print)

| | | | | | |
|----------------|--|---------------------|--|----------------------|------|
| Physician Name | | Physician Signature | | Date (mm/dd/yyyy) | |
| Street Address | | | | | Unit |
| City | | Province | | Postal Code | |
| | | | | Telephone Number () | |
| Fax Number () | | | | | |

DRUG REQUESTED FOR SPECIAL REIMBURSEMENT (Please Print)

Product name, dosage and quantity (requested for reimbursement): _____

Specific clinical and diagnostic evidence supporting the use of this medication: _____

Identify reasons why this drug product is now prescribed: e.g. patient's history, risk factors, concurrent use of other drugs (list drugs) failure to respond to or experienced adverse reactions to other drugs

Identify other drugs prescribed currently or previously for claimant's condition (as identified above): _____

Expected Duration of Therapy:

For non-orally administered drugs, where will the drug be administered? Please indicate full name and address below.

- Patient's Home: Yes No
- Hospital: In-Patient Out-Patient
- Private Clinic: Yes No

Full name of Hospital or Clinic: _____ Address: _____

ADDITIONAL INFORMATION RELATING TO THE ABOVE REQUEST (Please Print)

PROCEDURES FOR SPECIAL REIMBURSEMENT

This special reimbursement request must be completed by your attending physician. The cost, if any, of obtaining this information is at the expense of the patient/plan member. Forward the completed form to:

OTIP Health Claims, 125 Northfield Drive West, PO Box 218, Waterloo ON N2J 3Z9

Upon receipt of the request and the relevant information, it will be reviewed to determine eligibility. In some cases, additional diagnostic or clinical information may be required. The information provided on this form is considered confidential.

AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** OTIP and its insurer to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, its insurer and their reinsurers and/or service providers, for the Purposes. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that OTIP's Privacy Policy is available at www.otipservices.com or by request.

Signature of Plan Member _____

Date (mm/dd/yyyy) _____

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.