claimsecure

SPECIAL AUTHORIZATION REQUEST

Fax Requests to 905-949-3029
OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

TO BE COMPLETED BY PATIENT

Plan Member	Group Number	Certificate Number

Patient Name	Relationship to Member	Street Address
	☐Self ☐Spouse ☐ Other	

City	Province	Postal Code	Telephone Number	Patient Date of Birth (YYYY/MM/DD)
			( )	

I hereby authorize any physician, hospital, insurance company, other healthcare professional and ClaimSecure to exchange information in connection with this claim for the purpose of special authorization/patient exception evaluation, adjudication of claims, and administration of my health benefit program. I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature	Date (YYYY/MM/DD)
X	

TO BE COMPLETED BY PHYSICIAN

Physician Name	Specialty Qualification	Date (YYYY/MM/DD)

Street Address	Physician Signature
	X

City	Province	Postal Code	Telephone Number	Fax Number
			( )	( )

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength

Diagnosis	Expected Duration of Therapy

Prior Therapy used for this Condition (if applicable)

Product Name	Strength

Reason for Discontinuation	Duration of Therapy

Product Name	Strength

Reason for Discontinuation	Duration of Therapy

Product Name	Strength

Reason for Discontinuation	Duration of Therapy

Therapeutic Rationale

- ☐ No other therapeutic alternative for patient's medical condition
- ☐ Prior therapy used was not effective
- ☐ Could not tolerate prior therapy
- ☐ Other (please provide explanation below, or on the back of the form, to expand on checked item(s))

INTERNAL USE ONLY

Approved	Effective Date (YYYY/MM/DD)	Expiry Date (YYYY/MM/DD)	Reviewer
☐Yes ☐No			