Plan Administration Office Address
45 McIntosh Drive
Markham, ON L3R 8C7
Phone: 1-800-668-7547 Fax: 1-905-946-2535
E-Mail: medical@boilermakersbenefits.ca

REQUEST FORM FOR OXYGEN EQUIPMENT AND SUPPLIES COVERAGE

BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

To the Patient: The details requested below are necessary in order for the Boilermakers' National Health and Welfare Plan (Canada) to determine your coverage. All Claims must be submitted within 12 months of the date of service. The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

PLAN MEMBER INFORMATION

BOILERMAKERS' BENEFIT CARD ID NUMBER	MEMBER'S SOCIAL INSURANCE NUMBER	MEMBER'S DATE OF BIRTH	
MEMBER'S LAST NAME	MEMBER'S FIRST NAME	TELEPHONE NUMBER	E-MAIL ADDRESS
PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S DATE OF BIRTH	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? ☐ **YES** ☐ **NO**

IF "YES", PLEASE PROVIDE INSURANCE COMPANY NAME _____

I AM RECIEVING A SOCIAL ASSISTANCE BENEFIT: ☐ **YES** ☐ **NO**

IF "YES", PLEASE NAME THE SOCIAL ASSISTANCE BENEFIT(S) YOU ARE RECIEVING: _____

CLAIM DETAILS (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

THIS APPLICATION IS: ☐ **RENEWAL** ☐ **NEW** IF "NEW", WHAT IS THE SET UP DATE? _____

DIAGNOSIS (PLEASE BE SPECIFIC):
_____

HAS AN APPLICATION BEEN MADE TO THE MINISTRY OF HEALTH FOR FUNDING? ☐ **YES** ☐ **NO**
IF "NO", PLEASE PROVIDE REASON:
_____
(If application has been made and funding denied, please attach the denial letter)

THE PATIENT HAS APPROPRIATELY TRIED OTHER TREATMENT MEASURES WITHOUT SUCCESS ☐ **YES** ☐ **NO**
IF "YES", PLEASE DESCRIBE:
_____

METHOD OF SUPPLY:
☐ **CONCENTRATOR** (Including back-up and portable cylinders)
☐ **CYLINDER** (Compressed oxygen for stationary and/or portability)

ANTICIPATED HOURS PER USE (EACH DAY): _____

NAME OF OXYGEN VENDOR (IF AVAILABLE): _____

DOES THIS PERSON SMOKE? **YES** ☐ **NO** ☐
IF "YES", ARE THEY PLANNING TO STOP?
_____

IS OXYGEN REQUIRED: AS A RESULT OF A WORK RELATED INJURY? ☐ **YES** ☐ **NO**

IS OXYGEN REQUIRED: AS A RESULT OF A MOTOR VEHICLE ACCIDENT?	☐ **YES** ☐ **NO**
IS OXYGEN REQUIRED: FOR SPORTS PURPOSES ONLY?	☐ **YES** ☐ **NO**

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READINGS WITH THIS REQUEST

☐ **G.P.** ☐ **SPECIALIST**

PHYSICAN'S NAME (Please Print): _____

PHYSICAN'S SIGNATURE: _____

PHYSICAN'S TELEPHONE NUMBER: _____

DATE: _____

MAILING INSTRUCTIONS (ONCE COMPLETED, PLEASE RETURN ALONG WITH ANY ORIGINAL PAID RECIEPTS)

BOILERMAKERS' NATIONAL BENEFIT PLANS (CANADA) ADMINISTRATION OFFICE: 45 MCINTOSH DRIVE MARKHAM, ON L3R 8C7	**TELEPHONE NUMBERS:** 1-905-946-2530 1-800-668-7547	**FAX NUMBER:** 1-905-946-2535	**E-MAIL ADDRESS:** MEDICAL@BOILERMAKERSBENEFITS.CA

Privacy Statement: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal information will be protected pursuant to applicable legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, unions, regulators, legal counsel, actuaries etc.) in order to manage the Plan and your entitlement to the Benefits of the Plan.

Questions related to the Privacy Policy of the Plan should be direct to the Plan Administration Office at 1-800-668-7547