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 FOR NURSING SERVICES COVERAGE

BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

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	SOCIAL INSURANCE NUMBER	MEMBER'S DATE OF BIRTH
MEMBER'S LAST NAME	**MEMBER'S FIRST NAME**	**TELEPHONE NUMBER**
STREET ADDRESS	**CITY/PROVINCE**	**POSTAL CODE**
PATIENT'S FIRST NAME	**PATIENT'S LAST NAME**	**MEMBER'S E-MAIL ADDRESS**

CLAIM DETAILS (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

DIAGNOSIS (INCLUDING ANY COMPLICATIONS OR EXTENUATING CIRCUMSTANCES):

_____
_____
_____

PROGNOSIS:

_____
_____
_____

DATE OF HOSPITALIZATION/CONFINEMENT (IF ANY):

_____

WAS SURGERY PERFORMED? ☐ **YES** ☐ **NO** **IF YES, PROVIDE DATE:** _____

PLEASE INDICATE ALL MEDICATIONS AND THERAPIES USED INCLUDING THE STRENGTH, DOSAGES, FREQUENCIES AND THE METHOD OF ADMINISTRATION OF EACH.

_____
_____

PLEASE INDICATE WHERE THE SERVICES ARE TO BE PERFORMED

_____

PLEASE INDICATE THE LENGTH OF TIME THESE SERVICES WOULD BE REQURED

_____

IS THE PATIENT: AMBULATORY _____ **BEDRIDDEN** _____

WHAT SPECIFIC DUTIES WILL THE NURSE PROVIDE? (CHECK ALL THAT APPLY):

Administering Medications	☐	Time Spent:
Monitoring Vital Signs	☐	Time Spent:
Changing Bandages/Dressings	☐	Time Spent:
Physical Therapy	☐	Time Spent:
Meal Preparation	☐	Time Spent:
Housekeeping	☐	Time Spent:
Activities of Daily Living	☐	Time Spent:
Companion	☐	Time Spent:
Other Duties: _____		Time Spent:

IN YOUR OPINION, IS THE SPECIALIZED TRAINING OF A REGISTERED NURSE (RN) REQUIRED?

_____

_____

IS THE NURSE(S) A MEMBER OF THE PATIENT'S FAMILY? ☐ **YES** ☐ **NO**

WILL THE NURSE(S) LIVE IN THE PATIENT'S HOME? ☐ **YES** ☐ **NO**

HAS THE PATIENT'S NEED FOR NURSING SERVICES BEEN CONVEYED TO THE CANADIAN HOME CARE ASSOCIATION PROGRAM OR ANY OTHER AGENCY? ☐ **YES** ☐ **NO**

IF YES, PLEASE PROVIDE THE NAME OF THE HOME CARE PROGRAM AND CONFIRMATION OF THEIR INVOLVEMENT. IF NO, PLEASE EXPLAIN WHY:

_____

_____

_____

_____

SIGNATURES

ATTENDING PHYSICIAN'S SIGNATURE: **DATE:**

_____

ATTENDING PHYSCIANS ADDRESS AND TELEPHONE NUMBER:

_____

_____

SIGNATURE OF PLAN MEMBER: **DATE:**

_____

SUBMIT THE COMPLETED NURSING SERVICES REQUEST FORM TO:

ADDRESS:

Boilermakers' National Benefit Plans (Canada) Administration Office
45 McIntosh Drive
Markham, Ontario, L3R 8C7

TELEPHONE NUMBER:

1-905-946-2530 or 1-800-668-7547

FAX NUMBER:

1-905-946-2535

E-MAIL ADDRESS:

MEDICAL@BOILERMAKERSBENEFITS.CA