**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 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**

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