



**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

PRESCRIPTION DRUG SPECIAL AUTHORIZATION FORM

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.

PATIENT INFORMATION			
BOILERMAKERS' BENEFIT CARD ID NUMBER	MEMBER'S NAME	MEMBER'S SOCIAL INSURANCE NUMBER	
MEMBER'S DATE OF BIRTH	MEMBER'S E-MAIL ADDRESS		
LAST NAME OF PATIENT	FIRST NAME OF PATIENT	MEMBER'S TELEPHONE NUMBER	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE
I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to give to the Boilermakers' National Benefit Plans (Canada) information regarding my health. I hereby authorize the Boilermakers' National Benefit Plans (Canada) to exchange information with other parties as required, only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.			
Date: _____		Signature of Patient: _____ <small>(If under 16 years of age, the signature of the Plan Member is required)</small>	

PHYSICIAN INFORMATION			
PHYSICIAN NAME	PHYSICIAN SIGNATURE	SPECIALITY	DATE (D/M/YR)
STREET ADDRESS	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
			FAX NUMBER

DRUG REQUESTED FOR EVALUATION	
PRODUCT NAME/STRENGTH/DOSE/DURATION OF TREATMENT: _____ _____	
DIAGNOSIS: _____ _____	
INJECTABLE-LOCATION OF ADMINISTRATION (CHECK ONE):	<input type="checkbox"/> HOME <input type="checkbox"/> PHYSICIAN'S OFFICE <input type="checkbox"/> HOSPITAL (IN-PATIENT) <input type="checkbox"/> HOSPITAL (OUT-PATIENT) <input type="checkbox"/> LONG TERM CARE FACILITY
PREVIOUS THERAPEUTIC HISTORY FOR ABOVE CONDITION (PLEASE INCLUDE RELEVANT LAB RESULTS): _____ _____	
PRODUCT NAME/DOSE/DURATION AND RESULT OR PRIOR TREATMENT: _____ _____	
ADDITIONAL COMMENTS PERTAINING TO MEDICATION/MEDICAL CONDITION: _____ _____	

PLEASE PROVIDE US WITH INFORMATION ON OTHER COVERAGE (PROVINCIAL OR PRIVATE) AS IT PERTAINS TO THIS PATIENT AND MEDICATION:

APPLIED FOR COVERAGE: YES NO APPROVED DENIED

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

Privacy Statement: The Boilermakers' National Health Plan (Canada), the Boilermakers' National Pension Plan (Canada) (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator will collect, maintain, use and disclose only the information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.

Rev Date: 1/1/2021