



**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 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.

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: _____
(If under 16 years of age, the signature of the Plan Member is required)

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):

- HOME
 PHYSICIAN'S OFFICE
 HOSPITAL (IN-PATIENT)
 HOSPITAL (OUT-PATIENT)
 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 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

Rev Date: 11/03/2014