NO SUB AUTHORIZATION REQUEST

Fax Requests to **905-949-3029**
OR Mail Requests to **Clinical Services, ClaimSecure Inc., Box 6500 Station A, Sudbury, Ontario, P3A 5N5**
OR Email Special.Authorization@Claimsecure.com
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

TO BE COMPLETED BY PATIENT

Plan Member	Group Number	Certificate Number

Patient Name	Relationship to Member	Street Address
	Self ☐ Spouse ☐ Other ☐	

City	Province	Postal Code	Telephone Number	Patient Date of Birth (YYYY/MM/DD)
			( )	

If you would like to receive a response/letter via email, please write your email address clearly to ensure accuracy otherwise, we will reply by mail.

OR If you are registered with eProfile and would like your response/letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.

☐ **Yes, please email the response/letter to the email I provided in my eProfile account.**
☐ **No, I do not wish to receive an email response at this time.**

All responses/letters that are emailed will not be followed up by a mailed response.

PLEASE NOTE: Some drugs may be excluded from coverage or may be excluded when prescribed for specific conditions. If you have any questions regarding drug coverage, please contact our Customer Response Centre at 1-888-513-4464.

PRIVACY CONSENT

Protecting your personal information:
At ClaimSecure, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information:
Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to evaluate your eligibility for products, price our products collect feedback on our customer service, process claims, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. Your certificate number is used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with:
We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, and other organizations that provide us services such as paramedical examiners, medical laboratories, specialty coverage providers, independent medical examiners, and pharmacies. As well, we may share your information with travel assistance providers, technology suppliers, and insurance or reinsurance companies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information:
We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by submitting a request to our Privacy Office at privacy@claimsecure.com. This includes choosing whether you receive customer experience surveys, and whether you want to receive information and offers from ClaimSecure using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights, such as access to or correction of your personal information, by emailing our Privacy Office at privacy@claimsecure.com.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

ClaimSecure uses personal information when making decisions related to products and services. These decisions may be made using automated processing.

Want to learn more? Please visit https://www.claimsecure.com/privacy-policy/.

AUTHORIZATIONS AND DECLARATIONS

I hereby:

1. **Authorize ClaimSecure, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with ClaimSecure or any of the foregoing, located inside or outside Canada, to exchange personal information when relevant and necessary for the evaluation of the eligibility for this drug, adjudication of claims and to ensure continuity of care.**

2. **Acknowledge that my personal information will be collected, used and shared as set out above; and that refusing to consent may result in delay or denial of my request.**

3. **Acknowledge that ClaimSecure reserves the right to audit the information provided on this form at any time for purposes that include preventing and detecting fraud and this consent extends to any audit of my claim(s).**

4. **I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose the information provided on this form to my benefit plan sponsor/employer for the purposes of reporting instances of fraud, waste or abuse suspected by ClaimSecure.**

5. **Confirm that, where the patient is a person other than myself, the patient has given their consent to provide their personal information and for ClaimSecure to use and disclose it as set out above.**

6. **Confirm that the information given is true, correct, and complete to the best of my knowledge. Failure to provide true, correct, and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.**

7. **Acknowledge that I am responsible for any cost required for the completion of this form.**

Signature (Patient/Member Signature) X	**Date (YYYY/MM/DD)**

TO BE COMPLETED BY PHYSICIAN

Physician Name	**Specialty Qualification**	**Date (YYYY/MM/DD)**
Street Address		**Physician Signature** X
City / **Province**	**Postal Code**	**Telephone Number** ( ) / **Fax Number** ( )

DRUG REQUESTED FOR NO SUBSTITUTION

Diagnosis

Product Name

INTERCHANGEABLE GENERIC DRUGS TRIED – MUST USE TWO GENERICS IF AVAILABLE

Generic Product Name (1)

Please select the applicable medical reason why the above generic drug cannot be used by patient:

Contraindication ☐ **Adverse Reaction** ☐ **Therapeutic Failure** ☐

Please specify the effects:

Generic Product Name (2)

Please select the applicable medical reason why the above generic drug cannot be used by patient:

Contraindication ☐ **Adverse Reaction** ☐ **Therapeutic Failure** ☐

Please specify the effects:

Additional Comments:

INTERNAL USE ONLY

Approved *Yes* ☐ *No* ☐	*Effective Date (YYYY/MM/DD)*	*Expiry Date (YYYY/MM/DD)*	*Reviewer*

Clear