Manulife

Individual Insurance

Prior authorization for home care, hearing aids, nursing, orthotics, prosthetic appliances, medical equipment, and supplies

You must select the item or device before you can begin. **Homecare and Nursing**

The purpose of this form is to obtain the medical information required to assess your request for homecare and nursing under your individual insurance extended health care benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Some sections must be completed by the insured while others must be completed by **a physician or nurse practitioner**. Completing this form does not guarantee your request will be approved. All costs incurred to complete this form are the insured's responsibility.

If you have a medical document from your physician or nurse practitioner requesting homecare or nursing, please keep it with you until you receive further instructions from us. Please **do not** register for homecare and nursing services from an authorized provider until you hear from us about whether your request has been approved or declined. You may also be referred to our homecare and nursing preferred provider.

Benefits are not payable for the following homecare and nursing services:

- meals and housekeeping, custodial care/respite, services in a hospital/long term care facility/chronic care unit/slow stream rehabilitation centre, supervision/monitoring, shopping/transportation to and from the home or medical practitioner, and a live-in caregiver

1 Insured member and patient information

To be completed by the insured

Plan number	**Identification number**	

Primary insured's name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Insured's address (number, street and apt.)	City or town	Province	Postal code

Patient's name (first, middle initial, last)	Patient's date of birth (dd/mmm/yyyy)	Relationship to insured

Patient's preferred daytime phone number	Patient's email address (optional)

Is the patient covered under any other plans or programs for homecare and nursing? ◯ Yes ◯ No

Note: If urgent care is required, please contact our Customer Service Centre at 1-800-268-3763 for further instructions.

2 Provincial/Territorial plans funding

To be completed by the insured

Most provinces offer some form of coverage to their residents. Your Manulife plan supplements the coverage provided by provincial/territorial plans. It is important that you or your physician or nurse practitioner apply to the applicable provincial/territorial program to ensure there are no delays in your reimbursement.

Have you applied to the provincial/territorial program for coverage? ◯ Yes ◯ No

◉ I live in Ontario and have applied to my provincial program.

◯ I live outside of Ontario and have applied to my provincial program.

If No, please explain:

For Ontario residents only

Are you using an Local Health Integration Network (LHIN)? ◯ Yes ◯ No

Please indicate the reason why you are not using LHIN for homecare and nursing:

Provide the Local Health Integration Network (LHIN) case manager's name, phone number, and email address:

Case manager name	
Phone number	Case manager email address

Number of hours of nursing care provided by LHIN:

RPN/RN	PSW

3 Physician or nurse practitioner information

To be completed by prescribing physician or nurse practitioner

Prescribing physician or nurse practitioner name	Designation	Telephone number	Extension
Address (number, street, suite)	City or town	Province	Postal code

4 Severity of medical condition

To be completed by prescribing physician or nurse practitioner

Diagnosis:

Is the condition palliative care? ◯ Yes ◯ No

Hospital discharge date: (dd/mmm/yyyy)

Type of homecare and nursing required: ☐ RN ☐ RPN/LPN ☐ PSW ☐ OT

Where will the homecare and nursing services be provided?

☐ Home ☐ Hospital/Long-term care facility ☐ Chronic care unit ☐ Slow stream rehabilitation

Recommended duration of care (check one in each column):

Number of **hours** per day	Frequency of service	Duration of treatment (check one)
☐ 1-4	☐ Daily	☐ Less than 3 months
☐ 5-8	☐ Weekly	☐ 3 – 6 months
☐ 9-12	☐ Bi-weekly	☐ 6 – 12 months
☐ 13-24	☐ Monthly	☐ Other (please specify)
	☐ Other	

Who will provide care during the times a homecare and nursing practitioner is not present?

Types of services requested (i.e. dressings, personal hygiene):

☐ ADLs ☐ Bloodwork ☐ Dressings ☐ Footcare ☐ Injections

☐ Medication administration ☐ Ostomy ☐ Vitals ☐ Other (Please specify)

List all medications to be administered by the nurse and specify the method and frequency.

Oral	Subcutaneous	IV

5 Physician or nurse practitioner authorization

To be completed by prescribing physician or nurse practitioner

I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in an Individual Insurance health file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Physician's signature	Date signed (dd/mmm/yyyy)

6 Insured signature and authorization

To be signed by insured

I confirm that:

- I, or one of my family members covered by my plan, need the homecare and nursing services identified on this form.
- The information I have given you in this request is true and complete.

I agree that Manulife can collect, use, keep, and share my personal information, or the personal information of my family members, to manage this claim.

I agree that Manulife can also use this information for these purposes:

- managing my plan
- assessing eligibility of homecare and nursing and processing homecare and nursing claims
- investigating and ensuring the quality and accuracy of claims
- patient assistance programs, if applicable

I agree that I acknowledge all exclusions in my policy, including:

- homecare and nursing services in excess of those in Manulife's guidelines or those Manulife deems to be usual, reasonable, and customary

I agree that these people and groups can share my personal information with Manulife to manage my claim:

- medical and healthcare professionals, such as my doctor, Manulife's doctor, pharmacist, and nurse practitioner
- Manulife's service providers, including preferred providers

If my Manulife plan requires me to obtain homecare and nursing services from a preferred provider, Manulife will contact me with the preferred provider to:

- give me information about the program
- arrange to have my prior authorization transferred to the preferred provider

I agree that a photocopy or electronic version of this authorization is valid.

Insured's signature	Date signed (dd/mmm/yyyy)
Patient's signature (if other than the insured)	Date signed (dd/mmm/yyyy)

7 Statement of confidentiality

The specific and detailed information requested in this form is required to process the insured person's prior authorization request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a financial service file. Information in this file will be used to process the application, offer and administer services, and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations, and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below.

Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, PO Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.

A copy of our privacy principles and practices is available at manulife.ca.

8 Mailing instructions

After all sections of this form are completed by the insured, physician or nurse practitioner, use the **Other** submission method on SecureServe to send this request electronically, or mail it to us at:

Manulife Individual Insurance
Health Claims Prior Authorization
PO BOX 670, STN Waterloo
WATERLOO ON N2J 4B8

Make a photocopy for your files. The original copies will not be returned. Manulife is not responsible for any costs incurred when completing the form with your physician or nurse practitioner.

The Manufacturers Life Insurance Company (Manulife)

Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.