BIGSTONE HEALTH COMMISSION

Bigstone Health Benefits Medical Supplies and Equipment
Prior Approval Form

BIGSTONE HEALTH COMMISSION PROTECTED WHEN COMPLETED

Section 1: Patient Information

Patient Name:		Date of Birth:
Patient Address:		Sex: M ☐ F ☐
Telephone #:	PHN #:	Client ID #:

Section 2: Prescriber Information

Prescriber's Name:	License #:
Telephone #:	Fax#:

Section 3: Client Health Information

Diagnosis:
Explanation of benefit requirement and specific details of item to be provided (MUST BE COMPLETED)
Is the benefit requested due to the result of an injury: YES ☐ NO ☐ If yes, please complete the following:
Where did the injury occur: When did the injury occur: Home: ☐ Work: ☐ Other: ☐
Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

Section 4: Equipment or Supplies requested

Description of Device	Benefit Code	Qty	Cost

Section 5: Provider Information

Provider Name:	Provider Number:
Telephone#:	Fax#:
I hereby certify that the information is true and complete: Provider Signature:	Date:

Office Telephone #: (780) 341-2777	Direct line: (780) 341-2776
Office Address: 16310 100 Avenue NW Edmonton, AB T5P 4X5	Office Fax: (780) 444-6521

PLEASE SUBMIT WITH COPY OF PRESCRIPTION