Print Form

Health Canada / Santé Canada

Health Canada Protected

NIHB OXYGEN AND RESPIRATORY MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Section 1: Client Information **Initial** ☐ **Renewal** ☐

Surname:		Date of Birth: (YYYY/MM/DD)	
Given Name(s):		Sex: M ☐ F ☐	
Street Address:		City:	
Province/Territory:		Postal Code:	
Client ID #:	[OR] Band #:	Family #:	

Section 2: Parent/ Legal Guardian/ Representative
If client is under one year of age and not registered, please provide parent's information.

Surname:		Given Name:		Date of Birth: (YYYY/MM/DD)	
Client ID#:		[OR] Band #:		Family #:	

Section 3: Prescriber Information (PLEASE PRINT)

Name and Title:		License / Billing #:	
Telephone #:		Fax #:	
Diagnosis:	Complications: ☐ Cor Pulmonale	☐ Pulmonary Hypertension	☐ Secondary Polycythemia, indicate Hematocrit % ___

Section 4: Client Health Information

Is the benefit requested due to the result of an injury: Yes ☐ No ☐
If **yes**, please complete the following:

Where did the injury occur:
Home ☐ Work ☐ Motor Vehicle Accident ☐
Other ☐

When did the injury occur:

Are any of these expenses covered under any other federal, provincial, territorial or private health care Plan? Yes ☐ No ☐

(OXYGEN ONLY)
Section 5: Oxygen Prescription

	Rest	Exertion	Sleep
Oxygen flowrate, LPM			
Number of hrs /day			

Section 6: Arterial Blood Gas and / or Oxygen Tests (OXYGEN ONLY)
Signed and dated oxymetry test must accompany this form if PaO2 is greater than 55mmHg. Future signed and dated oxymetry tests may be requested by NIHB for assessment. ABG results are required for initial oxygen set up, as well as the three month and one year assessments.

ABGs on room air: Yes ☐ No ☐
If no, specify % ___ flowrate.

Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2

Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)

Rest	Exertion	Sleep
Date:	Date:	Date:

Section 7: Benefit Requested **START DATE:** **END DATE:**

Description of Benefit	Benefit Code	Quantity	Cost	Manufacturer Name, Item Code # and Type

Section 8: Provider Information (PLEASE PRINT)

Name and Title:		Provider #:	
Telephone #:		Fax #:	

I hereby certify that the information provided above is true and complete. The NIHB Program reserves the right to request this form for audit purposes.

Provider Signature: Date:

HC/NIHB - Revised November 2010

Privacy statement

Health Canada also requires your authorization in order to collect information from your provider for services provided to you and paid for by the Non-Insured Health Benefits Program. The NIHB Program is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the NIHB Program collects, uses, discloses and retains your personal information in accordance with the applicable federal privacy laws and policies. Further details of the NIHB Privacy Code can be found on Health Canada website: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php.