Indigenous Services Canada | Services aux Autochtones Canada

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NIHB OXYGEN AND RESPIRATORY MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Protected

Please check box if appropriate: ☐ Palliative Care Client OR ☐ Expected date of discharge from Health Care facility: _____

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

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

Section 2: Parent/ Legal Guardian/ Representative (If the client is under 18 months of age and not registered, please provide parent's information.)

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID#:	Band #:	Phone #:

Section 3: Prescriber Information (PLEASE PRINT)

Name and Title:	Licence #:
Phone #:	Fax #:

Section 4: Client Health Information

Diagnosis:	**Complications:** ☐ Cor Pulmonale	☐ Pulmonary Hypertension	☐ Secondary Polycythemia, indicate Hematocrit % _____

Is the benefit requested due to the result of an injury: Yes ☐ No ☐ If **yes**, please complete the following:		**Oxygen Prescription (OXYGEN ONLY)**	Rest	Exertion	Sleep
Where did the injury occur: Home ☐ Work ☐ Motor Vehicle Accident ☐ Other ☐	When did the injury occur:	Oxygen flow rate, LPM			
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes ☐ No ☐ If yes, provide the details:		Number of hrs /day			

Section 5: Arterial Blood Gas and /or Oxygen Tests (OXYGEN ONLY)
(Signed and dated oximetry test must accompany this form if PaO2 is greater than 55mmHg. Future signed and dated oximetry tests may be requested by NIHB for assessment. ABG results are required for initial oxygen set up, as well as the three month assessment.)

ABGs on room air: Yes ☐ No ☐ If no, specify % _____ flowrate.					Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)		
Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2	Rest	Exertion	Sleep
					Date:	Date:	Date:

Section 6: Benefit Requested **START DATE:** **END DATE:**

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

Section 7: Provider Information (PLEASE PRINT)

Name and Title:	Provider #:
Phone #:	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:

Privacy statement: The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For more information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at www.tbs-sct.gc.ca/hgw-cgf/oversight-surveillance/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

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