NO SUB AUTHORIZATION REQUEST

Fax Requests to 905-949-3029
OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

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.

Please be advised, all response/letters that are emailed will not be followed by a mailed response.

I hereby authorize:

1. Any physician, hospital, insurance company, other healthcare professional, and ClaimSecure to exchange information in connection with this claim for the purpose of special authorization – patient exception evaluation, adjudication of claims, and administration of my health benefit program.
2. The exchange of information between patient assistance program administration companies and ClaimSecure for the purpose of ensuring continuity of care by locating, initiating and monitoring additional coverage or reimbursement assistance.

I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature	Date (YYYY/MM/DD)
X	

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

Clear