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

PATIENT INFORMATION

Patient Name	Group Number	Certificate Number	Relationship to Plan Member: ☐Self ☐Spouse ☐Other
Street Address			City
Province	Postal Code		Patient Date of Birth (YYYY/MM/DD)
Telephone Number Home	Work / Mobile		Preferred Time of Contact ☐ AM (8:30am to 12pm) ☐ PM (12pm to 5pm)
Email Address			

DRUG REQUESTED

Product Name	Strength	Regimen
Diagnosis		

PHYSICIAN INFORMATION

Physician Name	
Telephone Number	Fax Number

PATIENT ASSISTANCE PROGRAM (to be completed by plan member if applicable)

Are you registered with a patient assistance program for your prescribed medication? ☐ **YES or** ☐ **No**

If yes, please provide:

a)Case/File #:________________________

b) Case worker contact information – Name:_________________ Telephone Number:______________________

SPOUSAL PLAN (to be completed by plan member if applicable)

Do you have drug benefits coordinated with your spouse's drug plan? ☐ **YES or** ☐ **No**

CONSENT

I hereby authorize:

1. **The collection, use and disclosure of my personal information between ClaimSecure and any physician, healthcare provider, hospital, clinic, medically related facility, insurance company, government and third party: patient assistance program administration company for the sole purpose of seeking drug coverage.**
2. **ClaimSecure to contact me and contact other parties on my behalf for the above-noted purpose.**

I assume responsibility for any third party cost required for the completion of forms for the above-noted purpose. A photocopy of this authorization shall be as valid as the original.

Signature X	Date (YYYY/MM/DD)