



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](mailto:coveragenavigation@claimsecure.com)

PATIENT INFORMATION			
Patient Name	Group Number	Certificate Number	Relationship to Plan Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Street Address			City
Province	Postal Code		Patient Date of Birth (YYYY/MM/DD)
Telephone Home	Work / Mobile		Preferred Time of Contact <input type="checkbox"/> AM (8:30am to 12pm) <input type="checkbox"/> 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? <input type="checkbox"/> YES or <input type="checkbox"/> 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? <input type="checkbox"/> YES or <input type="checkbox"/> 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		Date (YYYY/MM/DD)	