**AUTHORIZATION REQUEST TO INCREASE THE ANNUAL NUMBER OF BLOOD GLUCOSE TEST STRIPS ELIGIBLE FOR REINBURSEMENT**

DECLARATION OF THE INSURED PERSON

| Section 1: Information about the plan member and the patient | | | |
|---|---|---|---|
| Name of Plan Member | Insurance Policy / Certificate | Name of Employer | |
| Name of Patient | Date of Birth (YYYY/MM/DD) | Telephone | |
| Address (house number and street name) | City/Town | Province | Postal Code |

**Section 2: Authorization to disclose personal information**

I certify that the information in this prior authorization request is complete, accurate and true.

I authorize physicians and other health care professionals, medical, paramedical or clinical institutions, care coordinators, members of SSQ's Preferred Pharmacy Network (outside Quebec only) and any public or parapublic organization, including the Régie de l 'assurance maladie du Québec, to disclose to SSQ Insurance (SSQ) any of my relevant personal information including and without limitation, any medical information and medical evaluations in connection with the processing of this request. I hereby waive their confidentiality obligation and authorize them to disclose the requested information to SSQ Insurance. In addition, I authorize SSQ Insurance to disclose to the previously named third parties any of my relevant personal information including and without limitation any medical information and medical evaluations in connection with the processing of this request.

Photocopies of this document have the same value as the original.

Signature of **patient** (parent/legal guardian) _____ Date _____

**IMPORTANT:**

All correspondence concerning this form will be sent to the address indicated in the participant's file.

**Send us this duly completed form by mail or by fax at: 1-855-453-3942.**

Telephone: 418-651-2588/1-800-380-2588 – Fax: 1-855-453-3942 Postal address: 2525 Laurier Blvd, P.O. Box 10500, Quebec City, QC G1V 4H6

**ssq.ca**

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DECLARATION OF THE PRESCRIBER

| Section 3: Information about the prescriber | | |
|---|---|---|
| Name of prescriber | Specialty | Licence No.: |
| Telephone | Fax | |
| I hereby certify that the information in this request is accurate:<br><br>Signature of **prescriber** _____ Date _____ | | |

**IMPORTANT:**

**Please do not provide any genetic test results**

## Section 4: Clinical information

**Conditions**

❒ Pregnant woman with diabetes (annual maximum of 3,000 test strips)

Pregnancy began on: _____

Expected date of delivery: _____

❒ Non-diabetic person at risk for severe symptomatic hypoglycemia (no annual limit)

Please specify the clinical condition: _____

## Section 5: Additional information