



## Supplementary Health Expense – Private Duty Nursing

### Section 1 – To be completed by Plan Member

Plan Policy Number: 6012

Plan Member – Last Name      First Name and Initial      I.D. #

Address      City      Province      Postal Code      Telephone Number

Birthdate (dd/mm/yy)      Gender  Male  Female

### If claim is on behalf of an eligible Dependent, please complete the following:

Dependent's – Last Name      First Name and Initial      Date of Birth (dd/mm/yy)

Relationship (i.e. spouse, daughter, son)

### Directions / Documents Required

The Plan will consider payment of services of a registered graduate nurse (RN) other than a nurse who ordinarily resides in your home, or who is a member of your or your spouse's family. Nursing services are limited to an overall maximum Benefit of \$5,000 per person every 5 calendar years.

A physician's statement recommending a private duty nurse must be received in the Fund Office on the first day of each month prior to the nursing services being incurred. Claims for private duty nurses will not be accepted unless the Fund Office is made aware in advance.

The patient is responsible for securing this form and for any charges made for its completion.

### Co-insurance Information

Do you or your dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form?  
 No  Yes    If yes, please provide:

Plan Member – Last Name    First Name and Initial      Date of Birth (dd/mm/yy)

Insurance Company    Address    City/Postal Code    Telephone Number      Policy Number

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law?  No  Yes

Does the person for whom you are submitting this claim have coverage through their Provincial Plan?  No  Yes  
Provincial Plan Number \_\_\_\_\_ in the Province of \_\_\_\_\_.



## Page 2 – Supplementary Health Expense

### Private Duty Nursing

#### Assignment of Benefits to the Supplier

I hereby authorize the Administrator of the Electrical Industry Insurance Benefit Trust Fund of Alberta to issue payment of all benefits relating to this claim directly to the following provider:

Name and address of provider (please print) and attach the invoice to this claim:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Plan Member

Date (dd/mm/yy)

#### Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the Insurer, Board of Trustees, Medical Consultant, or any of their authorized representatives for purposes of settlement of this claim.

I understand that under the terms of this policy, it is the patient's responsibility to submit evidence supporting his/her claim and incur any fee for obtaining this information.

-----  
Signature of Plan Member

Date (dd/mm/yy)

#### The following sections are to be completed by the Attending Physician

Please print clearly:

Attending Physician's - Last Name: First Name and Initial:

Address: City: Province: Postal Code: Telephone Number (include area code)

#### Private Duty Nursing - Questionnaire

To be Completed by the Attending Physician and signed by the Plan Member  
(Please Print)



## Page 3 – Supplementary Health Expense

### Private Duty Nursing

#### Private Duty Nursing - Questionnaire

To be Completed by the Attending Physician and signed by the Plan Member  
(Please Print)

Policy Number: 6012

Name of Patient:

Address of Patient:

1. Diagnosis (including any complications or extenuating circumstances):
  
2. Prognosis:
  
3. Dates of hospitalization/confinement (if any):
  
4. Was surgery performed?  Yes  No If yes, provide date(s):
  
5. Please indicate all medications and therapies used including the strength, dosages, frequencies and the method of administration of each:
  
6. Please indicate where the private duty nursing services are to be performed:
  
7. Please indicate the length of time these services would be required:
  
8. Is the patient ambulatory or bedridden?
  
9. What specific duties will care giver provide:
 

<input type="checkbox"/> Administer Medications	Time Spent:	<input type="text"/>
<input type="checkbox"/> Monitoring Vital Signs	Time Spent:	<input type="text"/>
<input type="checkbox"/> Changing Bandages/Dressings	Time Spent:	<input type="text"/>
<input type="checkbox"/> Physical Therapy	Time Spent:	<input type="text"/>
<input type="checkbox"/> Meal Preparation	Time Spent:	<input type="text"/>
<input type="checkbox"/> Housekeeping	Time Spent:	<input type="text"/>
<input type="checkbox"/> Activities of Daily Living	Time Spent:	<input type="text"/>
<input type="checkbox"/> Companion	Time Spent:	<input type="text"/>
<input type="checkbox"/> Other:	Time Spent:	<input type="text"/>
  
10. In your opinion, is the specialized training of a RN required?  Yes  No Could these be substituted by an RNA?  Yes  No; or an HCA?  Yes  No
  
11. Is the nurse(s) a member of the patient's family?  Yes  No
12. Does the nurse(s) live in the patient's home?  Yes  No
13. Has the patient need for nursing services been conveyed to the Home Care Program or any other agency?  Yes  No  
If yes, please provide confirmation of their involvement. If no, please explain:

Signature of Attending Physician:

Date (dd/mm/yy)

Signature of Plan Member

Date (dd/mm/yy)