PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

CONTINUOUS GLUCOSE MONITORING (CGM) INITIAL REQUEST FORM 1 YEAR APPROVAL

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 6 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for a CGM device or supplies. CGM coverage is not available under all Pacific Blue Cross plans. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)

Patient's birthdate (mm-dd-yyyy)	Patient's weight	Patient's height	Policy number	ID number	☐ Other insurance coverage

Street address	City	Province	Postal code	Daytime phone number (10 digits)

PART 2 — PHYSICIAN WHO IS MANAGING THE CGM TO COMPLETE

Physician's name	College ID

Street address	City	Province	Postal code

Physician's area of specialty: ☐ Endocrinologist ☐ Diabetes specialist ☐ Internal medicine

If physician completing this form is NOT an endocrinologist, please provide the following information regarding the patient's endocrinologist:

Endocrinologist's name	College ID

Street address	City	Province	Postal code

I certify that I am the primary physician in the management of this patient's Continuous Glucose Monitoring and that the medical information provided is accurate and current:

Physician's signature X	Date (mm-dd-yyyy)

PART 3 — CGM REQUEST INFORMATION

CGM make and model requested: Brand: _____ Model #: _____

PART 4 — PATIENT INFORMATION: To be completed by physician

All of the following criteria must be met in order to be considered for CGM:

☐ Type I diabetic
☐ Currently receiving insulin via an insulin infusion pump
☐ Patient demonstrates compliance with current diabetes regimen
☐ Patient has attended appointments with an endocrinologist or a diabetes specialist at least twice in the past year
☐ Patient has multiple unexplained hypoglycemic events OR hypoglycemia unawareness
☐ A1C is not in **physician-determined** optimal range
☐ **Attach a copy of the patient's most recent HbA1C test to this request form** — must be taken within the last six months

PART 5 — ADDITIONAL INFORMATION

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

PART 6 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	

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Pacific Blue Cross
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DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

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Toll-free: 1 844 419-2689

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