IRONWORKERS' HEALTH & WELFARE
TRUST FUND OF WESTERN CANADA

OXYGEN CONCENTRATOR ASSESSMENT FORM

Instructions for Completion: This form must be completed in full to avoid delay in assessing the claim. Once we have all the required information and have assessed the information, we will notify the claimant, in writing, regarding plan coverage. Please ensure all fields are completed in pen using blue ink.

1. PATIENT INFORMATION TO BE COMPLETED IN FULL BY THE CLAIMANT

YOU AND YOUR DEPENDENTS MUST BE INSURED UNDER YOUR PROVINCIAL HEALTH PLAN IN ORDER TO PARTICIPATE IN THIS GROUP INSURANCE PLAN.

DO YOU HAVE PROVINCIAL HEALTH COVERAGE? ☐ YES ☐ NO DO YOUR DEPENDENTS HAVE PROVINCIAL HEALTH COVERAGE ☐ YES ☐ NO

GROUP NUMBER	LOCAL UNION NUMBER	CERTIFICATE/SOCIAL INSURANCE NUMBER

LAST NAME	FIRST NAME

PHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH (MM/DD/YY)

2. PROVINCIAL FUNDING TO BE COMPLETED IN FULL BY CLAIMANT

Coverage for wheelchair benefits through your Benefit Plan are supplemental to any services you are entitled to through your provincial assistive devices program. Please be sure to contact your provincial plan to verify eligibility before applying for Oxygen Concentrator benefits with the Trust Fund.

Will a portion be covered by the provincial plan? ☐ Yes ☐ No	If no please indicate the reason why?

3. NAME OF PRESCRIBING PHYSICIAN

PHYSICIAN NAME:

ADDRESS			PHONE
CITY	PROVINCE	POSTAL CODE	FAX

SIGNATURE: DATE:

4. CURRENT MEDICAL INFORMATION TO BE COMPLETED IN FULL BY PHYSICIAN

Diagnosis:

Prognosis:

Condition: ☐ Ambulatory ☐ Non-Ambulatory

If Ambulatory how many hours per day?_____

What is the expected length of time the patient is required to use this oxygen concentrator?

Complete Next Page

5. PURCHASE INFORMATION TO BE COMPLETED BY THE SUPPLIER

NAME OF MEDICAL PROVIDER:

BRAND NAME:

MODEL NUMBER:

PURCHASE COST: **RENTAL COST:**

PLEASE ATTACH A BREAKDOWN OF COSTS AND A COPY OF PROVINCIAL PLAN APPLICATION IF APPLICABLE

6. AUTHORIZATION TO BE COMPLETED BY THE CLAIMANT

Release of Information:

I authorize the release of any information as requested in respect of this claim to Funds Administrative Service Inc. and the Insurer and certify that the information given on this form is true, correct and complete to the best of my knowledge.

Please note that any charge to obtain this information is the responsibility of the member. Furthermore, the completion of this form does not imply acceptance of the eligibility of coverage.

PLAN MEMBER NAME: **DATE**

(MM/DD/YY)

SIGNATURE OF MEMBER

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