Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6
Fax: 418-838-2134
1-877-838-2134

GROUP INSURANCE - HEALTH CLAIMS

REQUEST FOR REIMBURSEMENT OF A MEDICATION NOT INCLUDED IN THE DYNAMIC THERAPEUTIC FORMULARY (DTF) OR OF A BRAND NAME MEDICATION

IMPORTANT INFORMATION

- Any charges for the completion of this form are the member's responsibility.
- The member must complete sections A and C.
- If the request is for the reimbursement of a medication that is not included in the DTF, the attending physician must complete sections D and F. If the request is for the reimbursement of a brand name medication, the attending physician must complete sections E and F. The member must have read and understood the instructions provided in these sections.
- This request will be assessed based on the medical information provided and may be reviewed by our physician or pharmacist.

A - PATIENT'S IDENTIFICATION - To be completed by the member

Name of policyholder	Group no.	Certificate no.

Last name and first name of member	Sex M F	Date of birth YYYY MM DD

Address - No., street, apt.	City	Province	Postal code

Last name and first name of patient	Sex M F	Date of birth YYYY MM DD

Relationship to member	DIN (Drug Identification Number)

B - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

C - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section. I authorize Desjardins Insurance strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, use the personal information it may have about me in existing files that are now closed. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of member _____ **Date** _____

Signature of insured dependent aged 16 and over: **Date:**

PLEASE HAVE YOUR ATTENDING PHYSICIAN FILL OUT THE BACK SIDE OF THIS FORM.

D - MEDICATION NOT INCLUDED IN THE DYNAMIC THERAPEUTIC FORMULARY (DTF)
DECLARATION OF ATTENDING PHYSICIAN - To be completed by the physician.

- The medication for which you are applying for an exception is not included in the DTF and is currently covered at a lower percentage. If this exception is approved, the medication will be covered at a higher percentage.
- The exception will only be approved if the physician provides an acceptable medical reason to support why the patient is unable to take a therapeutic alternative listed in the DTF.
- The approved medication will be covered up to the lowest cost generic equivalent available on the market. If the patient cannot take the generic equivalent either, another acceptable medical reason will need to be provided in section E.

1. Drug prescribed (product name, strength, dosage): _____

2. What is the patient's diagnosis? _____

3. Has the patient tried an alternative drug listed on the DTF? ☐ Yes ☐ No

If yes, specify which drug(s): _____

4. What is the medical reason for the request? ☐ Contraindication ☐ Adverse reaction ☐ Therapeutic failure

☐ Other: _____

5. Please explain the medical reason given in question 4 and add any additional information relevant to the request:

E - BRAND NAME MEDICATION
DECLARATION OF ATTENDING PHYSICIAN - To be completed by the physician.

- The brand name medication for which you are applying for an exception is currently covered up to the lowest cost generic equivalent available on the market. If this exception is approved, the medication will be covered at the price provided for the brand name medication.
- The exception will only be approved if the physician provides an acceptable medical reason to support why the patient is unable to take the lowest cost generic equivalent available on the market.

1. Drug prescribed (product name, strength, dosage): _____

2. What is the patient's diagnosis? _____

3. Has the patient tried the generic version of the drug? ☐ Yes ☐ No

4. What is the medical reason for the request? ☐ Contraindication ☐ Adverse reaction ☐ Therapeutic failure

☐ Other: _____

5. Please explain the medical reason given in question 4 and add any additional information relevant to the request:

F - PHYSICIAN'S IDENTIFICATION - To be completed by physician.

Last name and first name of physician (PLEASE PRINT)

Address - No., street, suite | City | Province | Postal code

Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: **Date:**

Please send form by fax: 418-838-2134 or 1-877-838-2134
or by mail: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6