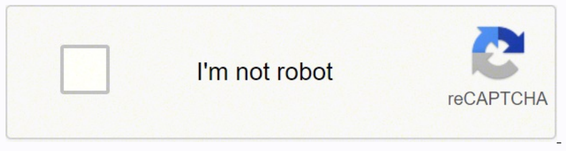

Open

Alberta blue cross forms

NAME:
DOB:
GENDER: MALE FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

2 WEEK CHECKUP CHILD HEALTH RECORD

HISTORY

See new patient history form

INTERVAL HISTORY:
NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues, including Maternal Depression: Y N
Findings:

DEVELOPMENTAL SURVEILLANCE
- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
Breastmilk
Min per feeding: Number of feedings in last 24 hrs:
Formula (type):
Oz per feeding: Number of feedings in last 24 hrs:
Water source: fluoride: Y N

*See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

Up-to-date
Deferred - Reason:

Given today: Hep B

LABORATORY

Newborn screening panel ordered today
Deferred - Reason:

Tests ordered today:

Signature/title

UNCLOTHED PHYSICAL EXAM

See growth graph
Weight: (%) Length: (%)
Head Circumference: (%)
Heart Rate: Respiratory Rate:
Temperature (optional):
Normal (Mark here if all items are WNL)
Abnormal (Mark all that apply and describe):
Appearance, Head/fontanels, Skin, Eyes, Ears, Nose, Mouth/throat, Neck, Heart/pulses, Lungs, Abdomen, Genitalia, Extremities, Back, Musculoskeletal, Hips, Neurological
Abnormal findings:

Additional:
Subjective Hearing Screening: P F
Subjective Vision Screening: P F
Newborn Hearing Screening:
ABR OAE Unknown
Completion date: / / Results:

HEALTH EDUCATION/ANTICIPATORY GUIDANCE (See back for useful topics)

Selected health topics addressed in any of the following areas*:
- Infant/Family Adjustment
- Parental/Maternal Well-Being
- Safety
- Nutrition/Feeding Routines

*See Bright Futures for assistance

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Alberta Health and Wellness

Application for Alberta Blue Cross Palliative Care Drug Coverage

Mailing Address: Alberta Health and Wellness, PO Box 1360 Stn Main, Edmonton AB T5J 2N3
In Person: To locate the office nearest you, please telephone our office or visit our website.
Telephone: 780-427-1432 Edmonton; Toll-free within Alberta yl 310-0000 then 780-427-1432
Fax: 780-422-0102
Website: www.health.alberta.ca

Before completing this application, please read the information provided on the back of this form.
All sections must be completed. *The application will be returned if information is omitted.*

To ensure this application reaches us as quickly as possible, please fax it to: 780-415-1704 or 780-422-0102. You can also return it by mail.

Applicant's personal information (Please print)

Personal health number
Last name | First name
Middle name | Date of birth | Male/Female | Telephone
Mailing address
City/Town | Province/Territory | Postal code
Patient/Parent/Guardian/Legal representative's signature | Date
If the patient did not sign above, please provide the following information: I am the patient's: parent of patient is under 18 / guardian / legal representative | Telephone
Patient/Parent/Guardian/Legal representative's last name (Please print) | First name | Middle name

This part to be completed by the attending physician or nurse practitioner

Is this the first time the patient has been enrolled in the Alberta Blue Cross Palliative Care Drug Coverage program, or is this an extension of coverage? New / Extension

If this is an extension, please refer to section 3 on the back. How long will coverage with the Alberta Blue Cross Palliative Care Drug Coverage program continue?

I confirm that the above-named applicant satisfies the eligibility requirements of the Alberta Blue Cross Palliative Care Drug Coverage program as defined in points 1(c) through 1(e) on the reverse, starting:

By signing this application I represent that:

- I have reviewed the patient's diagnostic, treatment and care information and I confirm that the patient is in the end-stage of a diagnosed terminal illness/disease which is expected to be the primary cause of death within three months or less.
- I am a member in good standing with the College of Physicians and Surgeons of Alberta or the College and Association of Registered Nurses of Alberta and competent to provide this confirmation.

I agree that the information in this section may be collected and used by Alberta Health and Wellness for enrolment in the Alberta Blue Cross Palliative Care Drug Coverage program.

Attending physician's name (Please print) | Practitioner ID
Attending nurse practitioner's name (Please print) | Practitioner ID
Business mailing address
City/Town | Province/Territory | Postal code
Signature of attending physician or nurse practitioner | Date | Office telephone number | Office fax number

Note to attending physician or nurse practitioner: Alberta Health and Wellness will contact you regarding extending coverage for your patient (see section 3 on back). To do this, we must record your Practitioner ID when the application is received. Therefore, it is important that you provide your Practitioner ID where requested.

AHC0022 (2009/04)

ALBERTA BLUE CROSS®

ALBERTA BLUE CROSS®

CLOPIDOGREL SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION
PATIENT LAST NAME | FIRST NAME | INITIAL
DATE OF BIRTH Year / Month / Day | ALBERTA PERSONAL HEALTH NUMBER
STREET ADDRESS | CITY | PROV | POSTAL CODE

COVERAGE TYPE:
Alberta Blue Cross
Alberta Human Services
Other
IDENTIFICATION/CLIENT/COVERAGE No.

PRESCRIBER INFORMATION
PRESCRIBER LAST NAME | FIRST NAME | INITIAL
STREET ADDRESS
CITY, PROVINCE
POSTAL CODE
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION: CPSA, CARNA, ACP, ADC, ADA+C, Other; REGISTRATION NO.
PHONE: | FAX:
FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage

For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion.*

For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request.*

For the prevention of ischemic events (cerebrovascular (e.g. stroke, TIA) or noncerebrovascular) in patients who have experienced an ischemic event while on ASA, or who have a contraindication to ASA. Special authorization for this criterion may be granted for 6 months.**

Coverage will not be considered when clopidogrel and ASA/dipyridamole are intended for use in combination.

*** Special Authorization for post-stent coverage is required when the prescriber prescribing the medication is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery; for treatment after repeat stents; or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.**

****This product is eligible for auto-renewal for the third criterion only.**

Section I For POST-STENT coverage, indicate the date and type of stent:
Date of stenting procedure:
Type of stent: bare metal stent (1 month of coverage) / drug eluting stent (12 months of coverage)

Section II For consideration of additional coverage, complete ALL sections:
Please indicate the ischemic event experienced (if applicable):
Cerebrovascular: stroke / TIA Noncerebrovascular (please specify):
Please indicate which anti-platelet therapy this patient was on when the ischemic event occurred: ASA / other (specify): / Patient was not on anti-platelet therapy
Does this patient have a contraindication/intolerance to ASA? YES / NO

RENEWAL
This product is eligible for auto-renewal for the third criterion above. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).
Please indicate response to therapy:

PRESCRIBER'S SIGNATURE | DATE | Please forward this request to: Alberta Blue Cross, Clinical Drug Services, 10009-108 Street NW, Edmonton, Alberta T5J 3C5. FAX: 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

ALBERTA BLUE CROSS®

MEDICAL SUPPLIES CHECKLIST

	Custom foot orthotics	Orthopedic shoes	Surgical stockings
Before buying			
If your plan requires a physician's written order, you will need the original prescription outlining the related medical diagnosis		✔ Must be prescribed by a physician, podiatrist or chiropractor	✔ Must be prescribed by a physician
If your plan requires a physician's written order, you will also need a copy of a biomechanical assessment	✔ Must be completed by a physician, podiatrist, chiropractor or physiotherapist		
When buying			
You must go to an authorized Alberta Blue Cross provider to purchase your custom foot orthotics, orthopedic footwear and surgical stockings	✔ Must be purchased from a podiatrist, chiropodist, physiotherapist, chiropractor, pedorthist or orthotist	✔ Must be purchased from a podiatrist, pedorthist or orthotist	✔ Must be purchased from a licensed medical supplier, and the pressure gradient must be included on the receipt (only pressure gradient of 30mmhg or more will be eligible)
You must have the provider complete a fabrication form for foot orthotics and orthopedic shoes	✔ Must be completed by a podiatrist, chiropodist, physiotherapist, chiropractor, pedorthist or orthotist	✔ Must be completed by a podiatrist, pedorthist or orthotist	

When submitting your claim, please include the following:

- A completed claim form
- An itemized receipt showing that payment was made in full
- A copy of the written prescription (as required by your plan) and an outline of the medical diagnosis (for orthopedic shoes and surgical stockings)
- A completed biomechanical assessment (for custom foot orthotics)
- A completed fabrication form (for foot orthotics and orthopedic shoes)

Alberta blue cross forms special authorization. Alberta blue cross group forms. Alberta blue cross forms for reimbursement. Alberta blue cross drug authorization forms. Alberta blue cross forms health spending account. Alberta blue cross forms health services claim. Alberta blue cross special auth forms. Alberta blue cross forms non group.

Application Application for Benefits ¢ÃÂÂ Employee Statement Application for Benefits ¢ÃÂÂ Employer Statement Attending Physician Statement Long Term Disability Claim Baggage claim form Use these forms to submit cancellation, interruption and baggage claims. Please Note: If you have access to benefits under an employer or similar plan, and choose not to use them, you will not be eligible for assistance under the EHB Specified Disease Conditions, EHB Seniors or MÃ©Âtis Benefits Programs. It must be submitted along with a Health Spending Account Claims form, and must be signed by your employer. Health/Dental Plan Rate Reimbursement Form This form is used to request reimbursement of your health or dental plan rates. Health and Dental Application Health and Dental Changes Submit this form to report any changes to an existing employee's status. Consent to Disclose Personal Health Information Use this consent form if you are 18 years of age or older and want Alberta Blue Cross to provide personal health information to another individual. Health Services Claim form This form is used to submit claims for products or services such as prescription drugs, private or semi-private hospital accommodation, ambulance, psychology services, physiotherapy, chiropractic, wheelchairs, vision care and hearing aids. The types of claims that you may submit through your account are described in detail on the claim form. You need to attach your confirmation of payment from the other plan carrier, otherwise your claim will not be processed. If you have already arranged for your payments to be withdrawn automatically from your account, but need to change your bank, or bank account information, you may use this form. (Beneficiaries receive benefits upon the death of the insured.) Confirmation of illness If you are submitting a Short Term disability claim for an absence related to the coronavirus and do not have an Attending Physician Statement, we require you ro latnem ot eud tnedneped ylluf tub, tcartnoC puorG eht ni deificeps sa ega tnedneped eht revo, dlihc deirramnu na ro, sisab emit-lluf a no noitutitsni lanoitacude detidercca na gnidnetta si ohw tcartnoC puorG eht ni deificeps ega mumixam eht rednu tub ega tnedneped eht revo dlihc deirramnu na eralced ot mrof siht timbuS noitaralceD tnednepeD egA-revO srebmem nalp laudividnI rof ylnO egnahc eman a fo su yfitoN .mrof eht no sserdda eht ta su ot ti liam ro xaf dna, ti ngis, ti ot "dioV" dekram euqehc a hcatta esaelp, mrof eht gnitelpmoc retfA .tcartnoC puorG eht ot erehda tsum segnahc esehT .tsoP adanaC aiv syad ssenisub 01 nihtiw detseuqer uoy stnemucod eht dnes ll'eW.) reywal a ro dneirf a, evitaler a, dlihc, esuops ruoy sa hcus (tluda rehtona ot noitamrofni htlaeh lanosrep ruoy edivorp ot ssorC eulB atreblA tnaw, elpmaxe rof, yam uoY .etis eruces rebmem nalp eht hguorht enilno tisoped tcerid rof gniretsiger yb emit evaS .tcartnoc nalp ruoy fo ypoc a ro sdrac DI tnemecalper tseuqer ot mrof enilno siht timbuS sdrac DI tnemecalpeR .tsrif nalp ralimis ro reyolpme ruoy hguorht mialC .sutats s'eeyolpme gnitsixe na ot segnahc yna troper ot mrof siht timbuS segnahC tifeneB eeyolpmE yrotsiH kroW dna noitacudE stifeneB ytilibasiD rof mroF tisopeD tceriD mrof egnahc ssecca dna tcatnoC. nalP eciohC lanosreP ro eciohC eulB a ot ega fo syad 03 rednu nrobwen a dda ot desu osla si mrof sihT .tnuocca ruoy morf stnemyap ylhtnom ekat ot noissimrep su sevig mrof tnemeergA) DAP (tibeD dezirohtuaerP ehT tnemeergA) DAP (tibeD dezirohtuaerP .ycilop ruoy ni detangised yraicifeneb eht fo su yfiton ot mrof siht timbuS egnahC ro tnemtnioppA yraicifeneB .llac uoy nehw dnah no drac noitacifitnedi ssorC eulB atreblA ruoy evah esaelP) syadiloh yrotutats desolc, yadirF ot yadnoM (MP 00: 5 Â Â Ã ¢ MA 03 : 8: SRUOH) EERF LLOT (0380-166-008-1: ENOHP .Noitidnoc Ruoy Rof Deviecer Evah YNA DNA SmotPmys Ruoy MRIFNOC OT MROF SIHT a odamalcer rebah ed s©Ãupsed atreblA ed luzA zurC al ed dulaS ed soicivreS ed n³ÃicamalceR ed oiralumroF le eÃvne y etelpmoc ,otreibuc ¡Ãtse on latot otsoc le iS .odavirp oruges ed nalp nu o serodajabarT sol Â n³ÃicasnepmoC y dadirugeS ed n³ÃisimoC al ed s©Ãvart a arutreboc neneit o soicifeneb selat anoicroporp euq rodaelpme nu arap najabart eguyn³Ãc us o detsu euqrop nalp orto ojab racifilac aÃrdop detsu ,olpmeje roP .sulP htlaeH o sulP sroineS ,derussA eulB nalp us a ograc a railimaf o eguyn³Ãc nu ragerga arap oiralumrof etse ecilitU ograc a railimaf nu ragergA .dulaS ed soicifeneB ed amargorP sit©ÂÃM o ;BHE rop sadacificepse dademrefne ed senoicidnoc ed amargorP ;sroineS BHE amargorP :ne adartsiger ratse ebed anosrep aL .etnerefid otneimitnesnoc ed oiralumrof nu renetbo arap etneilC la soicivreS ed otnematraped ortseun noc otcatnoc ne esagn³Ãp ,oiralumrof le ramrif o rednetne ed o selanosrep senoisiced ramot ed zapacni se n³Ãicamrofni ed duticilos al ed otejbo se euq anosrep al iS .eciohC lanosreP y eciohC eulB senalp sol arap OLOS etneidneped nu eugergA .soiretirc sotse nalpmuc euq soiralumrof yah on ,somitnes oL ejaiv ed n³Ãicpurretni e ejaiv ed n³Ãicalecnac ed oiralumroF nalp led selaudividni sorbmeim arap ol³ÃS aenÃl ne n³Ãiccerid ed oibmac nu raivnE selacsif sotcefe a obicer raticiloS .dade¼Ãgitna ed saÃd 03 ed s¡Ãm agnet euq lanosrep o luza n³Ãiccele ed nalp us a etneidneped nu ragerga arap oiralumrof etse ecilitU .l©Ã ed s©Ãvart a oslobmeer us arap dulas al noc sodanoicaler selbigele somalcer raivne arap oiralumrof etse rasu edeup ,dulas ne otsag ed atneuc anu eneit detsu iS n³ÃicamalceR ed oiralumroF dulaS ne otsaG ed atneuC n³ÃicamrofnI / sodanoicaleR soicivreS 5C3 J5T BA ,notnomdE WN teertS 801 Â ¢Ã 90001 secivreS htlaeH ssorC eulB atreblA ¦â Â ¢ÃdatelpmoC amroF al ed oÃvnE .obicer led aipoc anU ,o/y ;n³Ãicamalcer al ed latot otsoc le erbuc es on is nalp led atsitropsnart orto ed ogap led n³Ãicamrifnoc al atnujda eS .dademrefne of his other plan. 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