



**BIGSTONE HEALTH COMMISSION**  
Bigstone Health Benefits Medical Supplies and Equipment  
Oxygen and Equipment Prior Approval Form

BIGSTONE HEALTH COMMISSION  
PROTECTED WHEN COMPLETED

**Section 1: Client Information**

Client Name:		Date of Birth:
Client Address:		
Telephone #:	PHN #:	Client ID #:

**Section 2: Prescriber Information**

Prescriber Name:	License #:
Telephone #:	Fax #:

**Section 3: Client Health Information (MUST BE COMPLETED)**

Diagnosis:	Reason for request:
Explanation of benefit requirement and specific details of item to be provided:	
Is the benefit requested due to the result of an injury: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please complete the following:	
Where did the injury occur: Home: <input type="checkbox"/> Work: <input type="checkbox"/> MVA: <input type="checkbox"/> Other: <input type="checkbox"/> When did the injury occur?	
Are any of these expenses covered under any other public or private health care plan: Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Section 4: Equipment or Supplies requested**

Description of benefit	Benefit Code	Qty	Cost Per Unit

**Section 5: Provider Information**

Provider Name:	Provider Number:
Telephone #:	Fax #:
I hereby certify that the information is true and complete:	Date:
Provider Signature:	

Bigstone Health Benefits	
Office Telephone: (780) 341-2777	Direct Line: (780) 341-2776
Office Address: 16310 100 Avenue NW Edmonton, AB T5P 4X5	Office Fax: (780) 444-6521

**Submit with the following:**

- Signed prescription that includes oxygen flow (in liters per minute or pulse dose) and usage in a number of hours per day for each state of rest, exertion, and sleep
- Most recent testing information: ABG or Oximetry
- Additional information supporting the request for items, if available