BIGSTONE HEALTH COMMISSION

Bigstone Health Benefits Medical Supplies and Equipment
Respiratory 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 ☐ NO ☐ If yes, please complete the following:
Where did the injury occur: When did the injury occur? Home: ☐ Work: ☐ MVA: ☐ Other: ☐
Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

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: Provider Signature:	Date:

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 pressures for breathing apparatus**
- **Level I, level III or IV (oximetry) baseline and treatment sleep studies with summary tracings and physician impression**
- **Evidence of baseline hypercapnia (e.g, ABG, capillary blood gas or transcutaneous CO2 reading), and nocturnal hypoventilation (oximetry accepted); and evidence of improvement with therapy (BPAP-ST only)**
- **Additional information such as:**
  - **Height: _____ centimeters**
  - **Weight: _____ kilograms**
  - **Sleepiness scale (ESS): _____**
  - **Risk factors _____**