Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta T6E 5R6
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Fax: (780) 465-0808 Email: claims@ebfa.ca

Supplementary Health Expense -

CPAP Machine and Supplies

Section 1 - To Be Completed By Plan Member

Plan Policy Number: 6012

Plan Member – Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City: Province: Postal Code: Telephone Number:

Cell Phone Number: Birth date (dd/mm/yy): Gender: ☐ Male ☐ Female

Claimant Information:

Patient Name:	Date of Birth (dd/mm/yy):	Relationship to Plan Member:

Co-insurance Information

Do you or your dependents have any other coverage for the expenses being claimed on this form?
□ **Yes** □ **No** **If yes, please provide:**

Name of Insured: _____ Name of Insurance Company: _____

Date of birth (dd/mm/yy): _____ Plan Policy Number: _____

Plan Member ID Number: _____ Plan Effective Date: _____

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law? □ Yes □ No

Does the person for whom you are submitting this claim have coverage through their Provincial Plan? □ **Yes** □ **No**
Provincial Plan Number _____ **in the Province of** _____**.**

Directions

Claim forms must be signed and dated, or they will be returned for completion.

Section 2 of this claim form are the documents to be provided with a claim or pre-authorization of a CPAP Machine, or replacement parts of the CPAP Machine.

Please have the Attending Physician complete Section 3 of this claim form if pre-authorizing or claiming a CPAP Machine, or if you are claiming for CPAP related supplies for a CPAP Machine previously purchased but not reimbursed by the Fund Office.

If submitting for CPAP related supplies for a CPAP Machine which has been considered by the Fund Office, a receipt or invoice is to be provided with this claim form.

If replacement parts are required for supplies other than filters, tubing and masks, the reason for the replacement is required in writing from the Plan Member or provider.

A co-insurance statement of payment or denial is required if the claimant has co-insurance.

Claims may be assigned to the provider by signing the "Assignment Of Benefits To The Supplier" section of the claim form and providing an invoice.

The patient is responsible for securing this form and for any charges made for its completion. Failure to answer all questions on this form will delay payment of your claim.

Electrical Workers' Benefits Plan ALBERTA

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CPAP Machine and Supplies

Section 1- This submission is for:

Standard CPAP Machine ☐ Auto CPAP Machine ☐ CPAP supplies ☐

Section 2 - Documents to be Provided CPAP Machine

Standard CPAP Machine

1. We require a referral from the physician for the CPAP machine including the diagnosis.

2. We require a copy of the sleep study and the interpretation of the sleep study from the sleep specialist, including the AHI data.

3. If the submission is for preapproval only, we require two quotes for the equipment from independent providers. The quotes must include the patient's name, date of quote and a breakdown of the charges (for the CPAP machine and related medical supplies).

4. If patient is a resident of Ontario, Manitoba, or Saskatchewan, proof of provincial funding is required.

If the CPAP is a replacement, we require:

a. a letter from the sleep clinic or respiratory therapist stating the reason that the existing appliance needs to be replaced and the age and type of the existing CPAP machine,
b. a copy of the sleep study if EBFA did not receive a previous CPAP claim,
c. if replacing a standard CPAP with an Auto CPAP, the physician's referral must include the reason why a standard CPAP will no longer be effective, and
d. if the submission is for preapproval only, we require two quotes for the equipment from independent providers. The quotes must include the patient's name, date of quote and a breakdown of the charges (for the CPAP machine and related medical supplies).
e. If the CPAP machine is less than 5 years old, a repair quote and date of warranty expiration is required.

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Auto CPAP Machine

1. We require a prescription from a medical doctor for an AUTO-CPAP (at the end of the CPAP trial) with the medical diagnosis (including any medical conditions that would necessitate the need for an AUTO-CPAP), including the reason why a standard CPAP machine is not effective and why the AUTO-CPAP is required.

2. We require a copy of the sleep study and the interpretation of the sleep study from the sleep specialist, including the AHI data.

3. Please have the physician provide details of any other medical conditions the patient may have that would necessitate the use of an Auto CPAP machine.

4. We require the patient's required water pressure setting. The respiratory therapist who monitored the Auto-CPAP trial must provide data regarding variance in water pressures, if any.

5. If the submission is for preapproval only, we require two quotes for the equipment from independent providers. The quotes must include the patient's name, date of quote and a breakdown of the charges (for the CPAP machine and related medical supplies).

6. If a resident of Ontario, Manitoba or Saskatchewan, proof of provincial funding is required.

If the Auto CPAP is a replacement, we require the following:

a. a letter from the sleep clinic or respiratory therapist stating the reason that the existing appliance needs to be replaced and the age and type of the existing CPAP machine,
b. a copy of the sleep study if EBFA did not receive a previous CPAP claim,
c. if replacing a standard CPAP with an Auto CPAP, the physician letter must include the reason why a standard CPAP will no longer be effective, and
d. if the submission is for preapproval only, we require two quotes for the equipment from independent providers. The quotes must include the patient's name, date of quote and a breakdown of the charges (for the CPAP machine and related medical supplies).
e. If the Auto CPAP machine is less than 5 years old, a repair quote and date of warranty expiration is required.

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CPAP Machine and Supplies

Section 3 – To Be Completed by Plan Member or Provider

For replacement CPAP machine parts, please provide:

Reason for replacement:

_____

_____

_____

☐ I confirm the replacement part(s) is not covered under CPAP machine warranty

Completed by (Plan Member or Provider // Please Print): Signature: Date (dd/mm/yy):

Section 4 - To Be Completed By The Attending Physician

Please **print** clearly: Patient's Name: _____

Attending Physician - Last Name, First Name and Initial:

Address: Postal Code: Telephone Number:

Date treatment commenced (dd/mm/yy): _____

Recommended Medical Item(s): Standard CPAP Machine ☐ Auto CPAP Machine ☐ CPAP supplies ☐

A) Diagnosis of medical condition:

_____

_____

B) If recommending an Auto-CPAP machine, the reason the Standard CPAP is not effective, and why the Auto-CPAP is required:

_____

_____

C) **For replacement of a CPAP machine, please provide**:

Purchase date of previous CPAP Machine: _____ Type of previous CPAP machine (Circle one): Auto / Standard
Reason for replacement:

_____

D) Additional Comments:

_____

_____

_____

Signature of Physician Date (dd/mm/yy)

Please see page 4 – Plan Member must sign and date the claim form.

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CPAP Machine and Supplies

Assignment Of Benefits To The Supplier

I hereby authorize the Administrator of the Electrical Industry Insurance Benefit Trust Fund of Alberta to issue payment of covered expenses relating to this claim directly to the supplier named on the invoice. **(Do not sign this section if you are attaching paid receipts.)**

_____

Signature of Plan Member Date signed (dd/mm/yy)

Privacy Issues

I certify the charges for the CPAP machine and supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the medically necessary treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the insurer, Plan Administrator, Medical Consultant, Trustees or any of their authorized representatives for purposes of settlement of this claim.

Signature of Plan Member Date signed (dd/mm/yy)