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 –
Private Duty Nursing

Section 1 – To Be Completed By The 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 / Documents Required

The Plan will consider payment of medically necessary medical services (excluding Custodial Care, psychological or personal counselling) provided by a Registered Nurse (R.N.), Nursing Assistant (C.N.A., R.N.A., R.P.N., L.P.N. or L.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) while the patient is not confined to a Hospital; provided such nurse does not ordinarily reside in the home of the Plan Member or Spouse and is not a relative of the Plan Member, or Spouse. Services must be received in the patient's home (excludes nursing home). Nursing services are limited to an overall maximum Benefit of $5,000 per person every 5 calendar years. Reasonable and Customary rates will apply.

Section 2 must be completed by the **attending physician** (not the nursing company) answering all of the questions. The complete claim must be received in the Fund Office on the first day of each month prior to the nursing services being provided.

The **Nursing Agency** must provide written confirmation of: the name and address of the agency providing the Private Duty Nursing services, confirmation on the type of nurse that will be providing the services and the nurse's hourly rate being charged.

Claims for private duty nurses will not be accepted unless the Fund Office is made aware of the services in advance.

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

Page 2 – Supplementary Health Expense –
Private Duty Nursing

Section 2 To Be Completed by Attending Physician

Please print clearly:

Physician's Last Name, First Name and Initial: _____ Telephone Number: _____

Address/City/Province: _____ Postal Code: _____ Facsimile: _____

1) I prescribe Private Duty Nursing services for: _____
Patient's Name (Last Name, First Name)

2) Patient's medical diagnosis: _____

3) I recommend the above named patient for medically necessary Private Duty Nursing services: ☐ Yes ☐ No

4) Level of nursing required: _____

5) Please list the orders governing the care of this patient (and provide a copy of the orders): _____

6) A description of all medication being used, including strength, dosages and method of administration: _____

7) Number of hours / shifts the patient requires by day. If not a 24 hour shift, a description of who will provide care during the off hours:

8) Confirmation of the number of hours being provided through the Provincial Home Care nursing program:

9) Anticipated duration of nursing that will be required:

10) Please confirm where the Private Duty Nursing services are to be rendered / provided:

11) Please confirm that the person delivering the nursing services is not a relative of the Plan Member or the Spouse, and is not a resident within the home of the patient. ☐ Yes, is a relative or resides in the home. ☐ No, is not a relative and does not reside in the home.

12) Please provide a copy of the Home Care Assessment Report.

13) Please provide Nurse's records (where applicable).

_____
Signature of Physician Date (dd/mm/yy)

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

Page 3 – Supplementary Health Expense –

Private Duty Nursing

Section 3 To Be Provided by Nursing Agency

The Nursing Agency must provide a letter which includes the following information:

- the name and address of the agency providing the Private Duty Nursing services,
- confirmation on the type of nurse that will be providing the services,
- and the nurse's hourly rate being charged.

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 provider.

_____

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

Privacy Issues

I certify the charges for the Private Duty Nursing services 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 (dd/mm/yy)