Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: 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: Area Code and Telephone Number:

Birthdate (dd/mm/yy): Gender: ☐ Male ☐ Female

If This Claim Is On Behalf Of An Eligible Dependent, Please Complete The Following:

Dependent's – Last Name, First Name and Initial: Date of Birth (dd/mm/yy):

Relationship (i.e. spouse, daughter, son):

Directions / Documents Required

The Plan will consider payment of services of a registered graduate nurse (RN) other than a nurse who ordinarily resides in your home, or who is a member of your or your spouse's family. Nursing services are limited to an overall maximum Benefit of $5,000 per person every 5 calendar years.

A physician's statement recommending a private duty nurse must be received in the Fund Office on the first day of each month prior to the nursing services being incurred. Claims for private duty nurses will not be accepted unless the Fund Office is made aware in advance.

The patient is responsible for securing this form and for any charges made for its completion.

Co-insurance Information

Do you or your dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form?
□ Yes □ No If yes, please provide:

Plan Member – Last Name, First Name and Initial: Date of Birth (dd/mm/yy):

Insurance Company: Address: City/Postal Code: Area Code and Telephone Number: Policy Number:

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 _____.

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Page 2 – Supplementary Health Expense

Private Duty Nursing

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 all benefits relating to this claim directly to the supplier.

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

Privacy Issues

I certify the charges for the medical 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 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, Board of Trustees, Medical Consultant, or any of their authorized representatives for purposes of settlement of this claim.

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

Section 2 - To Be Completed By The Attending Physician

Please Print Clearly:

Name and Address of Patient:

Birth Date (dd/mmm/yy): Expected duration of treatment:

Diagnosis of medical condition with specific reason for recommendation of private duty nursing.

Date patient first consulted you for this condition.

Are you actively treating this patient for this condition? If no, please provide comments.

To the best of your knowledge, what is the duration period for use of private duty nursing services?

What are the recommended daily length of shift requirements required for the patient? Example, 8 hours, 16 hours

Please Print Clearly:

Physician - Last Name, First Name and Initial:

Address: City, Province: Postal Code: Area Code and Telephone Number:

Signature of Practitioner / Physician: Date: (dd/mm/yy)