



CONTINUOUS GLUCOSE MONITOR (CGM)
FLASH GLUCOSE MONITOR (FGM)
SPECIAL AUTHORIZATION REQUEST

MEMBER INFORMATION

SERVICE RECIPIENT (PATIENT) INFORMATION

Form with fields for Certificate Number, Client Number, Last Name, First Name, Address, City, Province, Postal Code, Email Address / Phone Number, and Service Recipient details.

COORDINATION OF BENEFITS INFORMATION

Form with questions A and B regarding other insurance benefits and carrier/program information.

PHYSICIAN SECTION (MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN)

Form with three numbered questions regarding prescribed systems, medical diagnosis, and intensive insulin therapy.

Text box for additional information to assist the clinical team in reviewing the request.

SEE REVERSE FOR DETAILS AND PHYSICIANS STATEMENT

## PHYSICIAN'S STATEMENT

Physician Name	Specialty
Clinic Name	Clinic Address
Phone Number	Fax Number
Physician Signature: _____ Date: _____	

## HOW TO SUBMIT CGM/FGM SPECIAL AUTHORIZATION REQUEST

email:	pharmacyservices@mb.bluecross.ca	Fax:	1.204.772.1231
Mail:	PO Box 1046 Stn Main Winnipeg, MB R3C 2X7	In Person/Drop Box:	599 Empress Street Winnipeg, MB

## CONSENT AND AUTHORIZATION

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member. I understand that Manitoba Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Manitoba Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Manitoba Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies or for questions as to the collection, use or disclosure of my personal information, I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

Service Recipient/Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

