New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

This form consists of five sections.

Each section is to be completed by a member of the applicant's diabetes care team. The prescribing physician completes Sections 1, 2, and 3. These are reviewed by the client's Diabetes Education Clinic.

Sections 4 and 5 are completed by the client and/or family and submitted directly to the IPP Business Office.

The application must be completed in full to be begin processing.

The **Approval Authorization Form** includes the following components:

Completed by Physician specialist

Section 1 – Basic Demographic

Section 2 – Medical criteria and Confirmation of Eligibility

Section 3 – Device and Supplies Requested

The physician's office forwards Sections 1, 2, and 3 to the client's Diabetes Education Clinic (DEC). The DEC reviews and submits the Sections 1, 2, and 3 to the IPP Business Office for processing.

**Add medical criteria and confirmation eligibility notes to the "Notes" area of Section 3

Completed by Client or Family/Guardian

Section 4 - Financial Contribution Assessment

Section 5 – Release of Information

The client/ family/guardian will mail the completed Sections 4 and 5 along with the supporting documentation to the IPP Business Office for processing.

For further information or assistance call 1-855-655-5525.







New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

Section 1- Basic	Demograp	hic
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Language	
of service:	

Name of Applicant:			Date of Birt	:h: (MM/DD/YYYY)			
Applicant's Current Mailing Address:		Medicare N	Medicare Number:				
			Applicant's	Current Telephone Number			
			Home	Cell			
Child (under 19) lives with:	_ Mother o	only Father only _	Both parents	sOther:	Gender:		
Applicant (19-25) status:	_ Single/W	/idowed/Divorced	Married/Commo	on-law Student			
Parental Information (if	applica	able)					
Key responsible parent, guardian	or agent n	ame:					
Address (if different from applica	nt):						
Telephone number (if different fro	om applica	nt): Home ()		Work (
Section 2 –Medical C	criteria	and Confirma	tion of Eli	gibility			
Most recent A1c results:	Date (MM/I	DD/YYYY)	A1c	Date (MM/DD/YYYY)	A1c		
Number of DKA episodes		t 6 months:		Last 12 months:			
Please confirm with a checkmark (v) each of the following	١			e team and reviewed at least 3			
statements		sick day management,	_	manage diabetes including carbohydrate counting, site rotation,			
		Appropriately self-mor paper or online and ag	_	d glucose, at least 4 times/day, i	recording results on		
		· · ·		fered by a certified pump traine	r		
The child has appropriate fami	ly suppor	t (if applicable)	Client atter	nds a diabetes care program	at:		
□ _{Yes} □ _{No}							
has type 1 diabetes and meets the medical eligibility criteria for the (Applicant's name) New Brunswick Insulin Pump Program.							
Physician's signature		Physician's na	me (please pr	int) Date			
I agree to actively attend and participate in the ongoing program for diabetes education, follow recommended guidelines insulin dosing, injection site rotation and sick day management as well as blood glucose monitoring as outlined in the treatment plan.							
	t Signatur		 Date				
Applicant analor ratent/Agen	t Jigilatul		Duic				







New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

Section 3 – Device and Supplies Requested			
Name of Applicant:			
Medicare Number:	Date of Birth: (MM/DD/YYYY)		
Device selection			
New pump user - The following device and su	pplies are requested		
Make	Model and supplies		
Existing pump user - The following supplies a	re requested for the indicated device		
Make (include year client received current device)	Model and/or supplies		
Replacement Pump Required (explain):			
Notes			
Notes			

Diabetes Education Centre faxes Sections 1, 2, and 3 to IPP Business Office: 1-855-290-2371







New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

Client and/or Family/Guardian(s) to complete Sections 4 and 5

The client and/or family/guardian(s) will complete:

Section 4 – Financial Contribution Assessment and **Section 5** – Release of Information

Sections 4 and 5 and the requested supporting documentation will be mailed by the applicant to the IPP Business office:

NB Insulin Pump Program
Tracadie-Sheila Hospital
PO BOX 3180 - 400, rue des Hospitalières
Tracadie-Sheila, NB E1X 1G5

Please refer to the **Insulin Pump Program (IPP) Policies and Procedures Manual** for assistance in completing the Approval Authorization From.

For further information or assistance call 1-855-655-5525.







New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

Section 4: Assessment of Financial Contribution						
Name of Applicant:			Date of Birth:	(MM/DD/YYYY)		
Applicant's Current Mailing Add	Jress:		Medicare Nun	nber:		
			Applicant's Cu	ırrent Telepho	one Number	
			Home		Cell	
Child (under 19) lives with:	Mother only _	Father only _	Both parents _	Other:		Gender
Applicant (19-25) status:	Single/Widowed	d/DivorcedN	Married/Common-	-law Stud	ent	
Parental Information	Parental Information (if applicable)					
Key responsible parent, guardia	in or agent name:					
Address (if different from applicant):						
Telephone number (if different from applicant): Home () Work ()						
Number of people living in household (children & parents within the household supported by family income):						
Net family income Household Member #1 (re	efer to CRA Notic	e of Assessme	ent): Line 150: _		Line 435:	
Household Member #2 (refer to CRA Notice of Assessment): Line 150: Line 435:						
Household Member #3 (refer to CRA Notice of Assessment): Line 150: Line 435:						

Section 5: Release of Information

Personal and private health information is required to be released to key partners as part of the business process and continuous quality improvement, involved in the Insulin Pump Program. These partners include the NB Insulin Pump Program Business Office, the selected pump vendor identified in Section 3 and their approved subcontractor(s), the Vitalité Health Network, Horizon Health Network and the New Brunswick Department of Health. Disclosed information may include personal information found in Section 1 and personal health information about the applicant in Section 2. As well the Business Office will inform the selected vendor and their approved subcontractor(s) of the family contribution that will be required towards the purchase of the pump and supplies. The vendor and their approved subcontractor(s) will also inform the Business Office of the mailing address and tracking number of the orders when shipped and report returns or discontinuation of supplies and/or insulin pumps as well as misuse of supplies. The Medical Approval Form will be kept by the physician and the Diabetes Clinic as part of your medical record. As well, a copy will also be kept by the Business Office. The mailed in Family Contribution Assessment Form with the appropriate documentation from line 150 and line 435 on the Notices of Assessment will also be kept. These documents will be stored in a secure filing system with access limited to authorized users. Precautions are in place to ensure that this information is appropriately secure, in accordance with government and regional health authority guidelines.

Continued on next page. >







New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

Section 5: Release of Information (Continued)				
Name of Applicant:				
Medicare Number:	Date of Birth: (MM/DD/YYYY)			
As well, all collected information from the form, will be Health, to evaluate the Insulin Pump Program and to their approved subcontractors may provide Vitalité He supply usage information. This data will be kept in a se the Vitalité, Business Centre will be retained long term the Department of Health will be retained to enable lor and preventing the development of complications in account.	identify opportunities for improve lealth Network and the Department ecure database, with access limited in accordance with the health record term benefit of this program in secondary.	ement. In addition, the vendors and nt of Health with pump device and I to appropriate users. Records with ord retention policy. The database in supporting the health of pump users		
I consent to Vitalité Health Network and the New Brunswick Department of Health collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive support from the Insulin Pump Program. In addition, I consent to Vitalité Health Network and New Brunswick Department of Health collecting, using, and disclosing personal information about me disclosed on this form for the purposes as described above related to the management of the Insulin Pump Program. I also consent to Vitalité Health Network and the Department of Health receiving insulin pump and supply usage information from the selected pump vendor and their approved subcontractor(s).				
All the information supplied above is true and correct to the best of my knowledge. I understand that if I choose to withhold or withdraw my consent to the collection, use, and disclosure of this information by Vitalité Health Network and New Brunswick Department of Health, I may be denied coverage under the Insulin Pump Program.				
The Vendor and their approved subcontractor(s) may offer a variety of services such as access to a vendor supported website for personal health information and insulin pump data download and analysis. I understand that I use these services or resources at my own risk and the services and resources are not endorsed in whole or in part by the Government of New Brunswick, Vitalité Health Network, or the Insulin Pump Program.				
If an applicant is less than 16 years of age, the legal gua or older should sign this consent. Applicants who are consent and the form may be signed by his/her agent.	16 years of age and older and un	nable to sign the form may give oral		
Client name (print) Signature of C	Client, Parent or Guardian	Date (MM/DD/YYYY)		

Please submit Sections 4 and 5 along with appropriate Canada Revenue Agency <u>Notice of Assessment(s)</u> for the most recent tax year to the address below. The family income considers in addition to an independent applicant, households occupied by two or more people related by birth, common-law union, marriage, or adoption. All incomes that contribute to the family income must be reported.

For further information or assistance call 1-855-655-5525.

NB IPP - Tracadie-Sheila Hospital PO BOX 3180 - 400, rue des Hospitalières Tracadie-Sheila NB E1X 1G5





