DRUG EXCEPTION REQUEST APPLICATION

Return completed form to:
Claim Secure Inc.
43 Elm Street
Suite 200
Sudbury, ON P3C 1S4
Attention: Drug Claims

Please note to ensure prompt accurate processing, please complete the form in full. Original receipts should be included if you have already purchased the drugs. Please include other medical conditions, which may have an impact on your present therapy (e.g. thyroid disorder, asthma, high blood pressure, chemotherapy). Any other comments which are relevant to this request including, prescribers' comments may be noted on a separate letter if available.

Employee Name: | Patient Name:

Relationship: | Date Of Birth:

Drug Card #: | Phone #:

Address:

Response Method Preference: Please check one

Email ____ Fax ____ Regular Mail ____

Email address (if preferred response method):____

Fax number (if preferred response method):____

Patient Consent

I certify that the information provided is true, correct and complete to the best of my knowledge. I understand that the purpose of this consent and release of information is to seek authorization and reimbursement for the medication listed below. I authorize the release of any information or records solely for the purpose identified. Additionally, I authorize to release, share and review this information with my physician, insurance company and other health care professionals as may be required solely for the assessment of my condition and administration of the Program. All information provided is confidential. The effective date of any approved drug exception will be the date signed below. An approval for acute (one-time only) medication will be effective for 60 days from the date this application is made.

_______________________________________ _______________________________

Patient Signature **Date**

Name of Drug (Brand and/or generic):

Strength and Dose of Drug: | Drug Identification Number (if known):

Diagnosis:

Type of Treatment: Acute (one time only): Maintenance (on going):

Drug Allergies, if applicable:

Type of Reaction (hives, breathing difficulty, etc.)

Previous Therapies:

Drug: | Result:

Other reason(s) why this medicine is medically necessary:

Claim Secure Use Only:

Completed and Approved by:_______________________________________ Date:_________________________

Claim Secure Representative

Revised August 2004