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Santé et Services sociaux Québec

DT9277

ELIGIBILITY FOR THE INSULIN PUMP REIMBURSEMENT PROGRAM (Pediatric)

Section 1: User

First and last name

Date of birth (Year / Month / Day)

Address (No., Street, apartment.)

City, province | Postal code

Phone No. (Area code)

Health Insurance No.

Email address of a contact person (for requests for additional information from authorized paying agent)

Section 2: Authorized prescriber

Last and first name	Practice number	Name of participating hospital/institution

Section 3: Type of application

☐ New application ☐ Renewal (Previous program user) ☐ Pump replacement for clinical reasons ☐ Withdrawal from program

Make of pump selected by user

☐ Supplies only

If user already has pump, date of acquisition (Year / Month / Day)

Section 4: Insurance coverage

Private insurance: ☐ Yes ☐ No **If yes, please complete section below:**

Insurer	Insurance holder	Policy or contract No.

I hereby authorize the paying agent as well as the insulin pump distributor to contact my insurer to verify my coverage for the Insulin Pump Program.

Insured's signature: _____

Section 5: Signature of authorized prescriber *(assessment valid 1 year)*

I certify that the abovementioned individual:

☐ Meets the clinical eligibility requirements

☐ No longer meets the clinical eligibility requirements

For the government insulin pump and supplies reimbursement program.

Authorized prescriber's signature	Date (Year / Month / Day)

Submit the form:

By mail:
Services financiers – CHU de Québec
775, rue Saint-Viateur
Québec QC G2L 2Z3

By email:
programmeinsuline@chudequebec.ca

By fax: 418 621-9926

Please ensure that all required sections of the form have been completed, and signed before returning it to the paying agent. A copy of the form must also be provided to the user.