



DT9276

Insulin Pump Program
ELIGIBILITY RENEWAL
(Adult)

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	Practice location

Section 3: Eligibility criteria (to be renewed annually)
<p>The user has shown the diabetes care team a commitment to meet <u>all</u> the following criteria:</p> <p><input type="checkbox"/> Consistently monitor capillary blood glucose at least before every meal and before bed (min. 4 times per day)</p> <p><input type="checkbox"/> Record capillary blood glucose results on a regular basis</p> <p><input type="checkbox"/> Master concepts of advanced carbohydrate counting, and apply them to his/her diet plan</p> <p><input type="checkbox"/> Attend regular check-ups at a diabetes clinic (min. 2 per year), follow a multidisciplinary diabetes management program in accordance with the recommendations of the treating physician, and regularly participate in updating knowledge about insulin pumps</p>

Section 4: Insurance coverage		
Private insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete section below:		
Insurer	Insurance holder	Policy or contract No.
<p>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.</p> <p style="text-align: right;">Insured's signature: _____</p>		

Section 5: Signature of authorized prescriber (assessment valid 1 year)					
<p>I certify that the abovementioned individual:</p> <p><input type="checkbox"/> Meets the clinical eligibility requirements</p> <p><input type="checkbox"/> No longer meets the clinical eligibility requirements</p> <p>For the government insulin pump and supplies reimbursement program.</p>	<p>Submit the form:</p> <p>By mail: Services financiers – CHU de Québec 775, rue Saint-Viateur Québec QC G2L 2Z3</p> <p>By email: programmeinsuline@chudequebec.ca</p> <p>By fax: 418 621-9926</p>				
<table border="1"> <thead> <tr> <th>Authorized prescriber's signature</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td></td> <td>Year Month Day</td> </tr> </tbody> </table>	Authorized prescriber's signature	Date		Year Month Day	
Authorized prescriber's signature	Date				
	Year Month Day				

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.