



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>
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.