

Prior Approval Request

Provider:	
Address:	
City:	Province:
Postal Code:	Phone Number: ()
Specialty:	Referring doctor:

1. Please include the patient's immigration document (IMM 1442), or client identification number and date of birth.

2. Diagnosis / Problem - including severity of symptoms

3. Special approval request (rationale): _____

4. Fee code, DIN, as applicable: _____

Please note: it is most efficient for the prescribing or referring doctor to obtain prior approval before sending patients.

Please forward your fax to:

Attn: Medical Director

Fax: 1-800-362-7456

Mailing Address:

219 Laurier Street

3rd Floor

Ottawa, ON K1A 1L1