IUOE Local 793

Private Duty Nursing Care Preapproval

Pension and Benefits
Administered by OEBAC

A Introduction

➔ Plan Members need this form to initiate a pre-authorization process for IUOE Local 793 Plan to cover private nursing expenses.

Please have your Physician complete the following form and return it to our office so we can determine the benefit allowance for nursing care coverage.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of any changes in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B Plan Member's information

For office use only
ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

C To be completed by Physician

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ABCDEFGH

Patient's Name	Diagnosis
Brief history of present illness	
Complicating factors	

Treatment expected to be required	From (yyyy-mm-dd):	To (yyyy-mm-dd):

Please provide a list of the medications to be administered and the type of administration for each.		
Nursing services to be performed by	☐ Registered Nurse	☐ Registered Nurse Assistant
Nursing services to be performed	☐ In Patients home	☐ In Hospital
Is the Nurse a member of the Plan Member's family?	☐ Yes	☐ No
Does the Nurse live in the Plan Member's home?	☐ Yes	☐ No

Please detail below the duties to be performed by the nurse, the frequency (how often), the duration (for how long), and the cost.

Duties to be performed	Frequency	Duration	Cost

Does the patient qualify for funding under alternative payer sources (community programs, support networks, government programs, etc.)? ☐ Yes ☐ No	If "Yes", please provide details:

D Signature of Physician

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Physician's Name	Physician's Signature	Date (yyyy-mm-dd)
Address		Phone #

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to

info@oebac.org