

**Pre-treatment / Estimate for
Continuous Glucose Monitor (CGM)**
To be submitted with initial CGM estimates only

Charges for completing this form or providing medical information are not covered by your plan.

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Plan member to complete parts 1 through 5, Physician to complete part 6
3. Attach estimate and retain copies for your files as originals will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See Part 7.

PART 1 - Confirmation, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services related to this form that may be claimed will be received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Plan Member signature X _____	Day	Month	Year
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PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name			
Plan number	Plan member I.D. number		
Plan Member Name			
First name	Last name		
Plan Member Address			
Number and street	City or town	Province	Postal code
Date of birth:		Language preference:	
Day	Month	<input type="checkbox"/> English	<input type="checkbox"/> French
Year			

PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? Yes No
If yes, please answer the questions below.
2. Who does the other insurance belong to? Self Spouse Child
Last Name _____ First Name _____
3. If the patient is a dependent child, please provide spouse's date of birth: **Day** _____ **Month** _____ **Year** _____
4. Is the other insurance also with Great-West Life? Yes No
If yes, please provide: Great-West Life plan number _____ ID Number _____
5. Is treatment required as the result of an accident? Yes No
If yes, what kind of accident? Motor Vehicle If other, please explain. _____

PART 4 - Patient Information

Patient name First name/Last name	Patient's Relationship to plan member Self Child Spouse	Patient's Date of birth			If child over 18 years		Does Patient Reside with Plan Member?	
					Full time student hours per week	Yes		
	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 5 - Estimate Expenses - Please attach a copy of your estimate

Type of Expense	Estimated Charges

Please have Part 6 completed by your prescribing Physician. This is required with your initial Continuous Glucose Monitor and/or associated supplies only.

PART 6 - Confirmation of eligibility for a Continuous Glucose Monitor and/or associated supplies (To be completed by Physician)

1. Are you prescribing/have you already prescribed a Continuous Glucose Monitor and/or associated supplies for the patient? Yes No
2. Please confirm the patient's medical diagnosis Type 1 diabetes Type 2 diabetes Other _____
3. Does the patient use insulin to manage their glucose? Yes No
4. Does the patient use a long-acting or short-acting insulin? Long-acting Short-acting

Physician's Name and Address _____

Registration Number _____


Physician's Signature _____

Date: Day Month Year

PART 7 - Submitting Your Form

Please send this form to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free:

 For the deaf or hard of hearing:
Toll Free: 1.800.990.6654