Manulife Financial

# Affinity Markets Oxygen Questionnaire
# Patient Information

## 1 Plan member/ patient information

| Plan number | Identification number | | |
|---|---|---|---|
| Patient's name (first, middle initial, last) | | has requested coverage from Manulife Financial for Oxygen Therapy. | |
| Address | City | Province | Postal code |
| Patient's date of birth (dd/mmm/yyyy) | Telephone number ( ) | | |

## 2 Care information

To be completed by a medical doctor.

| 1. Service | Currently receiving | Time limit | Application submitted |
|---|---|---|---|
| ◯ Home care | ◯ | | ◯ |
| ◯ Family benefits | ◯ | | ◯ |
| ◯ Worker's compensation | ◯ | | ◯ |

| | Yes | No |
|---|---|---|
| 2. Does your patient have or is he/she eligible for a "Drug Card" via Home care or Family benefits? | ◯ | ◯ |
| 3. Does your patient receive palliative care or have a terminal prognosis of less than three months? | ◯ | ◯ |
| 4. Is there a government program for Oxygen funding in your province of residence? | ◯ | ◯ |
| If "Yes," has the patient applied to the program? (attach a copy of the application form) | ◯ | ◯ |

If "Yes," what is the status of this application?

If "No," please indicate why no application was made

| | | |
|---|---|---|
| 5. Does the patient currently have an oxygen supplier? | ◯ | ◯ |

If "Yes," please indicate supplier

## 3 Severity of medical condition

Please indicate the severity of your patient's medical condition and corresponding need for oxygen.

Diagnosis

**Objective data supporting the existence of chronic hypoxemia (mandatory):**

| | Date (dd/mmm/yyyy) | $SaO^2$ by Oximetry | $PaO^2$mmHg* | $PaCO^2$mmHg* |
|---|---|---|---|---|
| At rest (room air) | | | | |
| And/or exercise | | | | |
| On oxygen | | | | |

* Please note that $PaO^2$mmHg or $PaCO^2$mmHg readings should only be indicated if available.

***Please complete page 2.***

## 4 Prescription and method of supply (mandatory)

| | Dosage of oxygen | | |
|---|---|---|---|
| | Rest | Exercise | Sleep |
| LPM (by nasal prongs) | | | |
| % by mask | | | |

Maximum number of hours to be used per day

## 5 Physician's signature

Physician's name (please print)

Signature of physician

Date signed (dd/mmm/yyyy)

Address

City

Province

Postal code

Telephone number
( )

Fax number
( )

Please note that Manulife Financial does not approve coverage for oxygen for subscribers who are eligible for this benefit under existing government programs. Patients eligible for partial funding will be considered for reimbursement of the amount not covered under any existing government program.

Please return all completed documentation to:

Manulife Financial Affinity Markets
Health Claims
PO BOX 4214, STATION A
TORONTO ON M5W 5M4

Telephone: 1-800-COVER ME® (1-800-268-3763)

Manulife Financial will not assume responsibility for any fees associated with the completion of this form.