

**Request for BPAP Funding for Clients with
BPAP Approved Prior to July 1, 2014**

B-NE

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21, 22 and 27 of the *Health Information Act* and sections 33, 34, 39 and 40 of the *Freedom of Information and Protection of Privacy Act (FOIP)* for the purpose of providing and determining eligibility for health benefits under the *Alberta Aids to Daily Living and Extended Health Benefits Regulation*. If you have any questions about the collection of this information, you can contact Alberta Aids to Daily Living Program, 13th Floor, TELUS House, 10020 100 Street NW, Edmonton, Alberta T5J 0N3 Telephone: 780-427-0731 Fax: 780-422-0968.

This form is completed for Clients with BPAP funding approved prior to July 1, 2014 who are now requesting BPAP funding for the new Service Delivery Model due to equipment failure.

This request needs to be uploaded to the Alberta Blue Cross Online Health Portal for funding to be considered.

Urgent for the following reason(s). **Please phone Alberta Blue Cross AADL Provider Line: 587-756-8629**

Client requires BPAP for hospital discharge or to prevent hospital (re)admission.

Client starts on BPAP and oxygen at the same time.

Other (specify) _____

1. Client's Name (Last, First) _____

PHN _____ Date of Birth (yyyy-mm-dd) _____ . _____ . _____

Address _____ Postal Code _____ Telephone Number _____

City _____

2. Respiratory Assessor (Last, First Name) _____

Designation RRT Other _____ Facility Name _____

Phone _____ Fax _____

3. Current Diagnosis

4. Authorization (Reference) number for BPAP supplies: _____

5. Reason for replacing BPAP equipment: _____

6. Has BPAP been replaced? Yes No

If yes, provide BPAP replacement date (yyyy-mm-dd) _____

Client Name: _____ PHN: _____

7. Date of the BPAP Prescription (*yyyy-mm-dd*) _____

Prescribed BPAP Settings:

Mode S S/T PC AVAPS iVAPS No substitutions

IPAP min _____ IPAP max _____ EPAP _____ Rate _____ Rise _____ Ti _____ Vt _____ Ramp _____ O₂ _____

Height (if prescribing iVAPS): _____

Other: _____

8. Prescribing Physician Name (Last, First) _____

Phone _____ Fax _____

Date (*yyyy-mm-dd*) _____ Signature _____

This form must be signed by the physician if there is a change in BPAP settings.

9. Comments: