GREEN SHIELD CANADA

# ERECTILE DYSFUNCTION
## SPECIAL AUTHORIZATION REQUEST FORM

Dear Plan Member:

**Please have the following Prescription Drug Special Authorization form completed in full by your physician.** If you are eligible for coverage by another plan (public or private) please have doctor indicate below. Your request will be reviewed and evaluated by our Drug Special Authorization Department who will communicate the results to you. Should you have any questions, you may contact our Customer Service Centre at 1-888-711-1119. **Please note: Incomplete and/or missing information may delay the processing of your request.**

## SECTION 1 – PATIENT INFORMATION

| Surname | Green Shield I.D. # | Employer Name |
|---|---|---|
| First Name | Date of Birth (Y/M/D) | Telephone Number |
| Street Address | City / Province / Postal Code | |

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to give to Green Shield Canada information regarding my health. I hereby authorize Green Shield Canada to exchange information with other parties as required, only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

**Date** _____ **Signature of Patient** _____

(If under 14 years of age, the signature of the plan member is required.)

## SECTION 2 – PHYSICIAN INFORMATION

| Physician Name | Physician Signature | Specialty | Date (Y/M/D) |
|---|---|---|---|
| Street Address | | Telephone Number | |
| City / Province / Postal Code | | Fax Number | |

## SECTION 3 – PATIENT'S MEDICAL INFORMATION – TO BE COMPLETED BY PHYSICIAN

**Medical condition contributing to erectile dysfunction (List disease states and/or medications):**

_____

_____

Duration of existing erectile dysfunction:

_____

_____

**Additional comments pertaining to medication/medical condition:**

**Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:**

Applied for other coverage: ☐ Yes ☐ No ☐ Approved ☐ Denied

## SECTION 4 – MAILING INSTRUCTIONS

**Once completed, please return request along with any original paid "Official Pharmacy" receipts to:**

**Green Shield Canada,**
**Drug Special Authorization Department,**
**P.O. Box 1606, Windsor ON N9A 6W1**

**Forms can be faxed or emailed: Fax: 1-519-739-6483 or Toll Free: 1-866-797-6483 or Email: drugspecial.autho@greenshield.ca**

**THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.**