Request
for Brand Name Drug Coverage

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St
PO Box 1500, Quebec QC G1K 8X9

Need help in completing this form?
Call us at 418 644-4200 or 1 800 463-4856.
You can download a printable version of this form from La Capitale's website at
lacapitale.com/groupforms

IMPORTANT

- The insured is responsible for any fees charged for the completion of this form.
- Please complete sections 1, 2 and 5 and have your physician complete sections 3 and 4.

This form is used to ask La Capitale Civil Service Insurer Inc. to examine a claim for a brand name drug that, for medical reasons, cannot be replaced by the least expensive equivalent drug available on the market. If your claim is approved, acceptance will apply for a determined period. You may have to submit a new request for a subsequent period.

Please send your duly completed form to the following address:
La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500
Quebec QC G1K 8X9

Or by fax at 418 646-0888 or 1 877 210-9766

1. IDENTIFICATION OF PARTICIPANT

As indicated on your insurance certificate

Group No.

Identification No.

or

Policy No. ___

Last name

First name

Please check the appropriate box

This claim concerns the: ☐ Participant ☐ Spouse ☐ Child

Complete this section only if your contact information has changed

NEW ADDRESS ONLY		
No., Street		Apartment
City	Province	Postal code
Telephone (home)	Telephone (work)	Telephone (cell)

2. INFORMATION ABOUT DEPENDENTS – Complete this section if you are submitting a claim for a dependent.

Spouse

Last name _____ First name _____

Date of birth (YYYY/MM/DD) _____

Dependent child Last name and first name	Date of birth (YYYY/MM/DD)	Full-time student	Complete this section if you are submitting a claim for a child over age 17 or 20, depending on your group insurance contract.	
			Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD)
		☐		

La Capitale Civil Service Insurer Inc. reserves the right to ask you for written proof from the institution attended at any time.

3. IDENTIFICATION OF ATTENDING PHYSICIAN

Last name	First name	
No., Street		Suite
City	Province	Postal code
Telephone	Fax	

4. ATTENDING PHYSICIAN'S STATEMENT

Drug prescribed: _____

Dosage: _____ DIN: _____

Diagnosis: _____

Adverse reaction: ☐ Contraindication ☐ Intolerance ☐ Other

Details: _____

_____

Other relevant information in support of the use of the brand name drug:

_____

_____

_____

I certify that all information provided on this form is accurate.

X _____ _____ _____

Physician's signature Licence No. Date (YYYY/MM/DD)

5. INSURED AND PARTICIPANT'S STATEMENT AND AUTHORIZATION

Insured

Last name _____ First name _____

Participant

Last name _____ First name _____

I authorize any healthcare professional or public or private healthcare institution, pharmacist, provincial prescription drug insurance plan, insurer, employer, rehabilitation company or other person or establishment holding medical or financial information concerning me to provide La Capitale with any information that it may consider necessary for the examination of my request.

I authorize La Capitale to carry out all investigations required to verify the validity of my request.

I understand that La Capitale or its representatives may use the information provided on this form and at the time of previous requests under this plan (if relevant) for the management of my file and the production of statistical reports.

I declare that the information provided on this form is true and complete.

A photocopy of this authorization is considered as valid as the original.

X _____ _____

Insured's signature Date (YYYY/MM/DD)

X _____ _____

Participant's signature Date (YYYY/MM/DD)

P014 (11-2017)