LiUNA Local 1059 Benefit Trust

Fax requests to ClaimSecure at 905-949-3029
OR Mail requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

MEDICAL CANNABIS REFERRAL FORM

Plan Member Information – Complete the following sections (Please print)	
Plan Member Name:	Patient Name:
Certificate No.:	
Patient Date of Birth (dd/mm/yyyy):	Preferred Phone Number:
Address (Number, Street, City, Province, Postal Code):	
May we contact you by email? (Note that some correspondence may still need to be sent by regular mail) ☐ Yes ☐ No	
If yes, provide the email address:	
Do you have coverage of medical cannabis with another carrier? ☐ Yes ☐ No If Yes, indicate the following below: (dd/mm/yyyy) Coverage provided by:	

Treating Physician Information Section – to be completed every 6 months	
Name of **Treating Physician**:	Specialty:
Address (Number, Street, City, Province, Postal Code)	
Telephone Number (Including area code):	Fax Number (Including area code):

1. Product Name: **Medical Cannabis**
2. Is your patient authorized to possess cannabis for medical purposes under current legislation? ☐ Yes ☐ No
3. Prescribed dosage form and regimen: _____
4. Diagnosis/indication for use(include date of initial diagnosis) (mm/dd/yyyy): _____|_____|_____

   ☐ Neuropathic/Chronic Pain ☐ Spasticity ☐ Palliative Care ☐ Anorexia

   ☐ Spinal Cord Injury ☐ Nausea/vomiting from chemotherapy treatment
5. What is the anticipated duration of treatment with medical cannabis? _____
   (not to exceed 6 months)

I certify that the information provided is true, correct and complete.

Treating Physician Name:	Treating Physician Signature:
Date (mm/dd/yyyy):	License Number:

Please note that legal access to cannabis for medical purposes is controlled in Canada through the Access to Cannabis for Medical Purposes Regulations. To comply with these regulations, only product purchased from a Health Canada authorized licensed producer will be eligible for reimbursement, excluding home producers.

I hereby authorize any licensed physician, healthcare provider, hospital, clinic, medically related facility, insurance company, patient assistance program administration company and ClaimSecure to exchange personal information relating to my health and this Medical Cannabis Referral request for the evaluation of the eligibility for Medical Cannabis, adjudication of claims and to ensure continuity of care.

I understand that personal information is needed for the above purposes and that refusing to consent may result in delay or denial of my request. I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada. I certify that the information given is true, correct, and complete to the best of my knowledge. I assume responsibility for any cost required for the completion of this form.

Plan Member Signature: X	Date: (mm/dd/yyyy):

A photocopy of this authorization shall be as valid as the original.