Alberta Government

Quantity & Frequency Review (QFR) Request for Respiratory Benefits

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the *Health Information Act,* sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act (FOIP)* and the *Alberta Aids to Daily Living and Extended Health Benefits Regulations* for the purpose of the determination eligibility for an AADL benefit. 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.

Palliative ☐

Please print clearly and ensure all applicable fields are filled out.
Only one benefit per QFR.

Alberta Blue Cross Respiratory QFR Fax Line: 780-498-3585

	Catalogue No.	Benefit Name	Assessment Date
Current benefit			
Requested benefit			

Client Information

Client's Name (Last) (First)	Diagnosis	Date of Birth *(yyyy-mm-dd)*	Personal Health Number

Name of Individual Legally Responsible for Client (if client unable to sign)	Individual's Relationship to Client

Mailing Address of Client / Individual Responsible for Client (to receive decision notice)	City	Postal Code

Client Residence Type ☐Home ☐ Long term care ☐ Group home ☐ Lodge Assisted living: ☐ SL3 ☐ SL4

Authorizer / Specialty Assessor (Auth / SA) Information

Auth / SA Name (Last) (First)	Phone Number	Fax Number	Authorizer Number

Reason for Request

Provide clinical rationale for your request. Attach required forms and documentation, as defined in the AADL Program Manual for the appropriate benefit area. Please refer to the QFR Checklist to ensure that the request meets basic eligibility criteria.

X _____ _____
Signature of Client / Individual Responsible for Client **Date *(yyyy-mm-dd)***

X _____ _____
Signature of Authorizer / Specialty Assessor **Date *(yyyy-mm-dd)***

Decision Information - This section for AADL use only

QFR Reference Number		Received Date	
Program Manager Decision	☐ Withdrawn ☐ Approved ☐ Denied	Decision Date	
Program Manager Name		Notice Date	

Rationale for Decision/Instructions to Authorizer or Specialty Assessor:

Notice: If this request is denied, the authorizer / assessor may submit it for reconsideration by the QFR Appeals Committee.
To request an appeal, mark below and resubmit this form to the QFR fax line. Additional information may be attached for review.

☐ Submit this request to the QFR Appeals Committee

Auth / SA Signature for Appeal	Appeal Request Date