Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

ORAL HEALTH EXCEPTION REQUEST

INSTRUCTIONS:

1. **Please don't use this form to request oral health exception (OHE) for permanently disabled over-age dependants. The *Oral Health Exception Request: Permanently Disabled Over-age Dependant* form should be used for this purpose.**
2. Please be aware that you're responsible for any fees charged by your physician for the completion of this form. Form fees for oral health exception requests are not covered by your plan.
3. Please have your physician submit the completed form to ASEBP by fax at 888-895-6837 or email at OHE@asebp.ca.
4. If you or your physician have any questions about the oral health exception process, please contact our ASEBP specialty claims coordinator at 780-431-4780.

Part 1: Patient Information *(to be completed by **patient**)*

A. Patient Information

Last name:	First name:		ASEBP ID:
Address:		Date of birth (YYYY/MM/DD):	
City:	Province:	Postal code:	Phone: ( )
For renewal requests, please indicate the OHE file number indicated on the renewal letter:	If the patient is someone other than the covered member, please indicate the patient's relation to the covered member: ❑ Spouse ❑ Dependant		

B. Consent to Collection, Use and Disclosure of Personal Health Information

The personal information contained in this form (with any supporting documentation provided) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit and administer the benefit plan. It may be necessary for ASEBP to disclose your personal information related to this notification to a third party service provider. When third party service providers are retained, appropriate contracts are in place to protect personal information.

I authorize my physician to disclose to ASEBP the information noted herein and any further information requested by ASEBP for the purpose of managing this oral health exception request.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my/our eligibility to receive benefits related to this oral health exception request.

I agree this authorization shall be in effect from the date below and shall be valid for the duration of time required to manage this request.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I agree to the above and declare that my statements in this form are complete, accurate and true.

VERBAL CONSENT WILL NOT BE ACCEPTED, FORM MUST BE SIGNED BY PATIENT OR PARENT/GUARDIAN.

Patient signature: _____ Date: _____

If patient is a minor, parent/guardian signature: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta, Schedule 1 of the federal Personal Information Protection Electronic Documents Act and, in relation to personal health information, section 34 of the Health Information Act of Alberta. If you have any questions regarding the collection, use or disclosure of your personal information, please refer to the ASEBP Privacy Policy at www.asebp.ca/privacy or contact the privacy officer at 780-438-5300.

Part 2: Clinical Information *(to be completed by **physician**)*

A. Prescriber Information			
Prescriber name:		CPSA #:	
Address:		City:	
Province:	Postal code:	Phone:	Fax (required):

B. Clinical Information	
Diagnosis:	Date of initial diagnosis: Month _____ Year _____

Please be advised that further information may be requested if needed to facilitate determination of coverage.

Physician signature: _____ Date: _____