Reset Form

Ontario Monitoring for Health Program Claim Form

Please mail completed form and original receipts to:
Monitoring for Health Program, 1000 – 170 University Ave., Toronto, ON M5H 3B3

To be eligible for the Monitoring for Health Program you must be an Ontario resident with a valid health card; use INSULIN to manage your diabetes OR have GESTATIONAL DIABETES; and have no other coverage for the diabetes testing supplies being claimed.

SECTION 1 – CLAIMANT INFORMATION (This section must be completed in full. Please print clearly)

Last Name	First Name	Middle Initial

Health Card Number (10 digits)	Version Code	Date of Birth	Gender
		m m d d y y y y	☐ M ☐ F

Address	Suite/Apt Number

City/Town	Province	Postal Code	Email
	ON		

Telephone Number (include area code)	Diabetes Canada Member	Type of Diabetes
	☐ Yes ☐ No	☐ Type 1 ☐ Type 2 ☐ Gestational

How did you hear about this Program?

SECTION 2 – CLAIM SUMMARY (Indicate the supplies and equipment for which you are submitting a claim)

Supplies must be purchased at an accredited Ontario pharmacy. Receipts must include date, item(s), amount paid, pharmacy name/address, etc. No photocopies. **Remember to include receipt(s) with claim form**.

☐ **BLOOD GLUCOSE TEST STRIPS AND LANCETS**
Coverage: 75% reimbursement, up to a maximum of $920 per year
$ _____

☐ **BLOOD GLUCOSE METER**
Coverage: 75% reimbursement, up to a maximum of $75, once every 5 years
$ _____

☐ **TALKING BLOOD GLUCOSE METER***
Coverage: 75% reimbursement up to a maximum of $300, once every 5 years
Note: For visually-impaired claimants only; letter from doctor required
$ _____

SECTION 3 – REIMBURSEMENT (Please choose either OPTION A or OPTION B. Contact your pharmacy for more information about Option B)

OPTION A

☐ Please pay to claimant listed above

If payment should be made to another individual (different from claimant listed above), please complete the following:

Name	Address	City/Town	Province	Postal Code

OPTION B

☐ Please pay pharmacy

I hereby assign reimbursement to the following pharmacy, where I purchased my blood glucose testing supplies.

_____ _____
Claimant Signature Date

Pharmacy Name	Address	City/Town	Province	Postal Code	Telephone Number (include area code)

Contact information for inquires (please do not email your claim form)
Tel: 416-363-0177 Toll-free: 1-800-361-0796 Email: mfhp@diabetes.ca

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SECTION 4 – CLAIMANT SIGNATURE

I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit/verification.

Claimant Signature

Date

SECTION 5 – PHYSICIAN OR NURSE PRACTITIONER SIGNATURE

NOTE: Signature needed on patient's FIRST claim only.

I certify that the patient named in Section 1 of this claim form uses insulin to manage his/her diabetes or has gestational diabetes.

Physician or NP Signature

Date

Physician or NP Name	CPSO or CNO Registration No
Telephone Number (include area code)	

SECTION 6 – FOR DIABETES CANADA OFFICE USE ONLY (Please do not write in this section)

Strips	Lancets	Meter	Talking Meter
ID #	Total Claim $	Approved by	