

**Quantity & Frequency Review Request**

Phone 780-427-0731

QFR faxline 780-644-1521

Please ensure that all parts of the form are filled out

	Cat. No.	Benefit Item Description	Submission Date
Benefit client has:			Y   Y   Y   Y   M   M   D   D
Requested benefit:			
<b>Client Information</b>			
Client's name (Last)	(First)	Diagnosis	Date of birth
			Y   Y   Y   Y   M   M   D   D
Client's address		City	Postal code
			( )
<b>Client Residence</b>			
<input type="checkbox"/> Home <input type="checkbox"/> Continuing care centre <input type="checkbox"/> Group home <input type="checkbox"/> Lodge                   Assisted living: <input type="checkbox"/> SL1 <input type="checkbox"/> SL2 <input type="checkbox"/> SL3 <input type="checkbox"/> SL4			
<b>Authorizer (Auth)/Assessor (As)/Vendor (Ven)/Specialty Supplier (SS) Information</b>			
Auth/As/Vendor/SS name (Last)	(First)	Phone number	Fax number
		( )	( )
Auth/As/Vendor/SS worksite and address		City	Postal code
<b>Reason for Request</b>			
Benefit specific forms <b>must</b> be attached. For faster processing, please ensure any documents are attached to the back of this form. Please ensure appropriate documents are completed in their entirety, as forms will be returned if any sections are left blank.			
<b>Provide clinical rationale and details:</b>			
Authorizer/Assessor/Vendor/Specialty Supplier signature: <b>X</b>		Client signature: <b>X</b>	
This Section for AADL Use Only		Logged in date: Y   Y   Y   Y   M   M   D   D	Appeals Coordinator: <b>X</b>
<b>Program Manager decision:</b>			
<input type="checkbox"/> <b>Approved</b>		Program Manager name: _____	
<input type="checkbox"/> <b>Denied</b>		Rationale for decision: _____	
Date: Y   Y   Y   Y   M   M   D   D		_____	
<input type="checkbox"/> Auth/As/Ven/SS notified <input type="checkbox"/> Logged		Instructions to Auth/As/Vend/Spec Supp: _____	
Date: Y   Y   Y   Y   M   M   D   D		_____	
<b>Notice to Auth/As/Vendor/Specialty Supplier(SS):</b> If your request has been denied by the Program Manager, you can appeal the decision to QFRC. To file an appeal, please check the box below and return this form to AADL.		<b>Decision:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Logged                   Date: Y   Y   Y   Y   M   M   D   D <input type="checkbox"/> CT and Auth/As/Ven/SS notified                   Date: Y   Y   Y   Y   M   M   D   D	
Auth/As/Vendor/SS name: _____		AADL signature: <b>X</b>	
Signature: <b>X</b>			
Date: Y   Y   Y   Y   M   M   D   D		<input type="checkbox"/> <b>Referred to QFRC</b>	

The personal information provided on this form is collected under the authority of the *Public Health Act* and the *Alberta Aids to Daily Living and Extended Health Benefits Regulation* and managed in accordance with the *Freedom of Information and Protection of Privacy Act*. The information will be used to determine eligibility for any requested items. If you have any questions about the collection of this information, contact the Disability Supports Division, 10040 - 104 Street NW, Edmonton, Alberta, T5J 0Z2, Telephone: 780-427-0731 Fax: 780-422-0968.