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:			
Requested benefit:			Y Y Y Y M M D D

Client Information

Client's name (Last)	(First)	Diagnosis	Date of birth Y Y Y Y M M D D	Personal health number
Client's address		City	Postal code	Phone number ( )

Client Residence

☐ Home ☐ Continuing care centre ☐ Group home ☐ Assisted living

Authorizer/Specialty Supplier (SS) Information

Auth/SS name (Last)	(First)	Phone number ( )	Fax number ( )	Auth. no.
Auth/SS worksite and address		City	Postal code	

Reason for Request

Benefit specific forms **must** 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.
Provide clinical rationale and details:

Authorizer/Specialty Supplier signature: **X**	Client signature: **X**

This Section for AADL Use Only Logged in date: Y Y Y Y M M D D | Appeals Coordinator: **X**

Program Manager decision:

☐ **Approved**
☐ **Denied**
Date: Y Y Y Y M M D D

Progam Manager name: _____

Rationale for decision: _____

☐ Auth/SS notified ☐ Logged
Date: Y Y Y Y M M D D

Instructions to Authorizer/Specialty Supplier: _____

Notice to Authorizer/Specialty Supplier(SS):
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.

Auth/SS name: _____

Auth/SS signature: **X** _____

Date: Y Y Y Y M M D D ☐ **Referred to QFRC**

Decision:
☐ Approved ☐ Denied
☐ Logged Date: Y Y Y Y M M D D
☐ CT and Auth/SS notified Date: Y Y Y Y M M D D
Appeals Coordinator: **X**

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