Π–HXc∃Φ–ΓFN4/1%

The 1986-1990 Hepatitis C Claims Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

Compensation for Costs of Care

Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED

* If you do not have the labels, call 1 877 434-0944 for instructions.

CORRECTIONS ONLY

Write any name, address or telephone number corrections below, if any corrections are necessary.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	City/Municipality	Province/Territory	Postal Code

PERSONAL REPRESENTATIVE OF THE HCV INFECTED PERSON

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City/Municipality	Province/Territory	Postal Code

SECTION B – TO BE COMPLETED BY TREATING PHYSICIAN

TREATING PHYSICIAN

3.	First Name	Middle Name/Initial	Last Name	
	Name of Facility	Mailing Address		
	City/Municipality	Province/Territory	Postal Code	
	Work Phone	Facsimile	E-Mail Address	Specialty
	( ) -	( ) -		

DISEASE LEVEL 6 – QUALIFICATION

4.	a)	The HCV Infected Person was assessed and approved at disease Level 6. Please indicate the earliest date that you believe the HCV Infected Person had one of the Level 6 Medical Conditions listed below.	DD/MM/YYYY / /
	b)	Indicate the date that the HCV Infected Person required Care due to one of the level 6 Medical Conditions listed below.	DD/MM/YYYY / /

☐ The HCV Infected Person has had a liver transplant

☐ The HCV Infected Person has been diagnosed with decompensation of the liver based on a finding of one or more of the following:
- ☐ hepatic encephalopathy
- ☐ bleeding esophageal varices
- ☐ ascites
- ☐ subacute bacterial peritonitis
- ☐ protein malnutrition
- ☐ another condition_____

☐ The HCV Infected Person has been diagnosed with hepatocellular cancer based on:
- ☐ a liver biopsy
- ☐ an alpha fetoprotein blood test
- ☐ a liver scan

☐ The HCV Infected Person has been diagnosed with B-cell lymphoma

☐ The HCV Infected Person has been diagnosed with symptomatic mixed cryoglobulinemia

☐ The HCV Infected Person has been diagnosed with glomerulonephritis requiring dialysis based on a kidney biopsy

☐ The HCV Infected Person has been diagnosed with renal failure

5. Was the care described item by item in Section D (see following pages) of this Form recommended/supported by another physician or yourself? If claiming for care given by a relative in the home, did you as a physician support/recommend it?

☐ Yes ☐ Yes except for items#_____

☐ No

Comments if any:

_____

_____

6. Did the HCV Infected Person's qualifying level 6 condition materially contribute to the recommendation of the above care?

☐ Yes ☐ Yes except for items#_____

☐ No

Comments if any:

_____

_____

SECTION C – CERTIFICATION BY TREATING PHYSICIAN

I certify that the information provided is true and correct to the best of my knowledge and belief.

_____ _____

Date of Signature Treating Physician's Signature

SECTION D – UNINSURED PERSONAL CARE IN THE HOME PROVIDED BY A FAMILY MEMBER

Please complete this section if you are claiming for personal care in the home that was provided by a family member. All "care services" must relate to your HCV infection. Any amounts collected under a public or private insurance plan must be disclosed.

Items	Start Date DD/MM/YYYY	End Date DD/MM/YYYY	Description of Care	Hours per week
1.	/ /	/ /		
2.	/ /	/ /		
3.	/ /	/ /		
4.	/ /	/ /		
5.	/ /	/ /		
6.	/ /	/ /		
7.	/ /	/ /		

SECTION E – UNINSURED COSTS OF CARE EXPENSES – CONTINUED

Please list all "care services" coupled with their individual costs. All "care services" must relate to your HCV infection. Any amounts collected under a public or private insurance plan must be disclosed. Please enclose all receipts.

Items	Start Date DD/MM/YYYY	End Date DD/MM/YYYY	Description of Care	Total Cost	Receipt Enclosed	Was This Expense Incurred Outside of Canada?	Amount Reimbursed by Health Plan	Amount Claimed
8.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
9.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
10.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
11.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
12.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
13.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$
14.	/ /	/ /		$	☐ Yes	☐ Yes Where: _____	$	$

SECTION F – CERTIFICATION
I certify that the information provided is true and correct. I am not making any false or exaggerated Claims to obtain benefits that I am not entitled to receive. _____ Date Signed _____ Claimant's Signature