



P.O. Box 1623
 WINDSOR, ON N9A 7B3
 Attention: EHS Department
 Customer Service Centre 1-888-711-1119 or (519) 739-1133

CLAIM FORM FOR CUSTOM FOOT ORTHOTICS

To the Patient: The details requested below are mandatory in order for Green Shield to determine our liability with respect to this request.

| PROVIDER | | | PATIENT | | |
|----------------|----------------------|-------------|-----------------------|---------------------------------|-------------|
| Provider No. | Telephone No. () | | Green Shield I.D. No. | Date of Birth ____/____/____ | |
| Name | | | Name | | |
| Street Address | | | Address | | |
| City | Province | Postal Code | City | Province | Postal Code |

Do you have any other Group Insurance coverage that may include these services as benefits? Yes No
 If yes, please provide Insurance Company name _____
 If other coverage is Green Shield, indicate Green Shield number _____

THIS SECTION MUST BE COMPLETED IN FULL BY THE DISPENSING AND/OR TREATING PHYSICIAN / CHIROPODIST / PODIATRIST / PROFESSIONAL.

1. I hereby prescribe/provide the following for the above named patient (Please include specifications):

2. Diagnosis (please be specific): _____

3. Please identify which diagnostic measures were included in the determination of need:
 _____ Biomechanical Examination _____ Bone Position Measurements _____ Stance and Gait Analysis
 Other _____
 • **Please include copy of applicable test results.**
4. Please describe previously attempted alternate therapies: _____

5. Is the device(s) and/or medical equipment required: as a result of a work related injury? Yes No
 as a result of a motor vehicle accident: Yes No for sports purposes only? Yes No

| | |
|--|---------------|
| Name of Physician / Chiroprapist / Podiatrist (Please Print) | Date |
| Signature | Phone No. () |

| | TREATMENT DESCRIPTION | DATE OF PICKUP YR MO DAY | CHARGES \$ |
|----|-----------------------|---------------------------------|------------|
| 1. | | | \$ |
| 2. | | | \$ |
| 3. | | | \$ |

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

Signature of Provider _____ Accreditation _____ Registered No. _____

THE PLAN MEMBER HAS PAID THE CHARGES LISTED ON THIS CLAIM IN FULL. PLEASE REIMBURSE THE PLAN MEMBER DIRECTLY.

I certify that the orthotics have been picked up and are in my possession and hereby authorize payment directly to the provider named above.

Signature of Provider

Signature of Patient

Date

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
 ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).