

PO Box 1623, Windsor, Ontario N9A 7B3  
 Attn: EHS Department  
**Customer Service Centre**  
**1-888-711-1119 or (519) 739-1133**  
**Fax (519) 739-0046**

**To the Patient:** The details requested below are mandatory in order for Green Shield to determine our liability with respect to this request. For prior approval, please forward this form to the address indicated. A response letter outlining our liability will be forwarded to the patient promptly. Our decision is not intended to interfere with or reflect upon the course of treatment recommended by your doctor. Failure to request pre-approval may result in a denial of your claim.

### SECTION I – MUST BE COMPLETED IN FULL BY THE PATIENT /GUARDIAN

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
 Address \_\_\_\_\_ Green Shield I.D. No \_\_\_\_\_  
 \_\_\_\_\_ Telephone No \_\_\_\_\_  
 \_\_\_\_\_ E-Mail Address \_\_\_\_\_

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 \_\_\_\_\_

### SECTION II - MUST BE COMPLETED IN FULL BY TREATING PHYSICIAN

1. I, as the attending Physician, hereby prescribe the following custom brace for the above named patient. (Please include specifications when available.)  
 (A) Type of Brace: \_\_\_\_\_  
 (B) Left \_\_\_\_\_ Right \_\_\_\_\_ Bilateral \_\_\_\_\_  
 (C) Estimated cost: \_\_\_\_\_
2. Condition of Patient: Acute \_\_\_\_\_ Chronic \_\_\_\_\_
3. Duration of Need: Weeks \_\_\_\_\_ Months \_\_\_\_\_ Year(s) \_\_\_\_\_ Lifetime \_\_\_\_\_
4. Diagnosis (Please be specific): \_\_\_\_\_
5. Past Treatments: Physio \_\_\_\_\_ # of Treatments Surgery \_\_\_\_\_ Medications \_\_\_\_\_ X-rays \_\_\_\_\_
6. Degree of joint space: Past/Future Loss \_\_\_\_\_ NA \_\_\_\_\_
7. Specify medically why a custom brace is necessary as opposed to a standard brace: \_\_\_\_\_  
 \_\_\_\_\_
8. Was brace shown to patient and costs provided? Yes  No
9. Is the prescribed item a replacement? Yes  No  If Yes, give reason \_\_\_\_\_
10. Has application been made for Government funding? Yes  No  If No, give reason \_\_\_\_\_  
 Not Applicable
11. Is the device(s) and/or medical equipment required:
  - As a result of a work related injury? Yes  No
  - A motor vehicle accident? Yes  No
  - For sports purposes only? Yes  No

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (Please Print) \_\_\_\_\_ Physician's Telephone Number \_\_\_\_\_

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.

ALL CLAIMS MUST BE RECEIVED BY GREEN SHIELD CANADA WITHIN 12 MONTHS OF THE DATE OF SERVICE.  
 THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.