

## 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.**

- I hereby prescribe/provide the following for the above named patient (Please include specifications):  
\_\_\_\_\_
- Diagnosis (please be specific): \_\_\_\_\_
- 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.**
- Please describe previously attempted alternate therapies: \_\_\_\_\_
- 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			CHARGES \$
		YR	MO	DAY	
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 SUBSCRIBER HAS PAID THE CHARGES LISTED ON THIS CLAIM IN FULL. PLEASE REIMBURSE SUBSCRIBER 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

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/SUBSCRIBER.  
 ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.