



CLAIM FORM FOR CUSTOM FOOT ORTHOTICS/FOOTWEAR

Please use one form per practitioner, per patient

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

SECTION 1 - PATIENT INFORMATION			PROVIDER INFORMATION		
PLAN MEMBER ID	DATE OF BIRTH (YY/MM/DD) ____/____/____		PROVIDER NUMBER	PROVIDER PHONE #	
SURNAME	FIRST NAME		PROVIDER NAME		
ADDRESS			ADDRESS		
CITY	PROVINCE	POSTAL CODE	CITY	PROVINCE	POSTAL CODE
EMAIL			EMAIL		

SECTION 2 - MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? YES NO
 If we are your secondary carrier, please attach Explanation of Benefit statement from primary carrier.
 If other coverage is with Green Shield Canada Insurance, indicate other Plan Member ID: _____
 Do you want to coordinate this claim with your other Green Shield Canada Insurance Coverage? YES NO

SECTION 3a - MUST BE COMPLETED IN FULL BY THE DISPENSING AND/OR TREATING: PHYSICIAN / CHIROPDIST / PODIATRIST / CHIROPRACTOR / PEDORTHIST / ORTHOTIST

1. I hereby prescribe/provide the following for the above named patient: Custom Foot Orthotics Orthopedic Shoes*
 * Please provide make and model of orthopedic shoes if applicable: _____

2. Diagnosis (please be specific): _____

3. Are the device(s) required:
 as a result of a motor vehicle accident? Yes No as a result of a work related injury? Yes No
 for sports purposes only? Yes No

If the Claim is for Custom Foot Orthotics, the following is also required:

1. Copy of diagnostic measures test results:
 Biomechanical Examination or Gait Analysis Other _____

2. Identify casting technique. Must create 3D volumetric model of patient's foot.
 Subtalar Neutral Cast(i.e. Plaster of Paris) Semi-Weight Bearing Cast (i.e. Foam Cast)
 3D Laser Scan Other, please indicate: _____

3. Copy of the lab invoice showing the raw materials used to construct the orthotic and the costs associated/ incurred in the manufacturing process.

The prescriber must sign in this box or attach the prescription to complete the processing of this claim.

Physician Chiroprapist Podiatrist Other _____

 NAME OF PRESCRIBER (PLEASE PRINT) PHONE NO. _____

 SIGNATURE DATE _____

SECTION 3b – CLAIM DETAILS

	TREATMENT DESCRIPTION	DATE OF PICKUP			CHARGES (\$)
		YY	MM	DD	
1.					\$
2.					\$
3.					\$

I certify that the treatment(s) above was performed by me and all information provided on this form by me is accurate.

 SIGNATURE OF PROVIDER DATE _____

 ACCREDITATION REGISTERED NO. _____

SECTION 4 - AUTHORIZATION AND CONSENT

At Green Shield Canada Insurance (“GreenShield,” “we,” “us” or “our”), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, “you” or “your”), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GreenShield, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer’s group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GreenShield’s third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

By signing below, you are providing your consent to GreenShield’s collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GreenShield at privacy.office@greenshield.ca, but, if you do so, GreenShield will no longer be able to administer your benefits plan and process your claims.

Name

Signature

Date

SECTION 5 - ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT.
PLEASE REIMBURSE PATIENT DIRECTLY.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

SIGNATURE OF PROVIDER

SECTION 6 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.

The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

EHS DEPARTMENT
P.O. BOX 1623
WINDSOR, ON
N9A 7B3

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

greenshield.ca