



P. O. BOX 1623
 Windsor, Ontario N9A 7B3
 Attn: EHS Department
 Customer Service Centre 1-888-711-1119 or (519) 739-1133

CLAIM FORM FOR CUSTOM FOOT ORTHOTICS/FOOTWEAR

To the Patient: The details requested below are mandatory in order for Green Shield Canada 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 / CHIROPDITST / PODIATRIST / CHIROPRACTOR / PEDORTHIST / ORTHOTIST.

- 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 _____
- Diagnosis (please be specific): _____
- Are the device(s) 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

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

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

Date _____

Name of Physician / Chiroprapist / Podiatrist (Please Print)

Physician Chiroprapist Podiatrist Other _____

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

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.
 By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

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).