GREEN SHIELD CANADA

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 ☐

_____ **Date** _____
Name of Physician / Chiropodist / Podiatrist (Please Print)

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.

Signature of Provider

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 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).