GREEN SHIELD CANADA

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

AUTHORIZATION FORM FOR CUSTOM BRACES

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

Subscriber Name			Green Shield I.D. No.	
Patient Name		Birth Date ___/___/___		Age
Street Address	City	Province	Postal Code	Telephone No. ( )

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 ☐

______________________ Date ______________________
Physician's Signature

______________________ ______________________
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 is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

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