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. 306758	Telephone No. ( )		Green Shield I.D. No.	Date of Birth ____/____/____
Name MELISSA ALLEN, D.P.M., R.CH			Name	
Street Address 2303 Howard Ave			Address	
City Windsor	Province Ont	Postal Code N8X3V4	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.	CUSTOM MADE ORTHOTICS				$
2.					$
3.					$

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

______________________	D.P.M., R.CH	100372
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 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.

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.