MANITOBA BLUE CROSS®

Is this: ☐ **A Claim?**
☐ **A Pre-Authorization Only?**

ORTHOTICS, ORTHOPEDIC SHOES, AND MODIFICATIONS CLAIM FORM

PATIENT

Contract Number _____ Group Number _____

Name _____

Address _____

City _____ Province _____ Postal Code _____

QUESTIONS 1-5 MUST BE COMPLETED BY THE MEDICAL PRESCRIBER.

1. Diagnosis (please be specific) _____

_____

2. What are the symptoms the patient has presented with? _____

_____

_____

3. What are the objective physical findings at the time of assessment? _____

_____

_____

4. Specific type of footwear required _____

5. Are the items 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

Signature of Prescriber _____ Date _____

Professional Qualifications of Prescriber _____

Name and Address of Prescriber _____

QUESTIONS 6 AND 7 MUST BE COMPLETED BY THE DISPENSING PROFESSIONAL.

6. Provide a full description of the item including name of shoe if purchased off the shelf. For shoes that were modified, please provide a detailed description of the shoe itself and the modifications performed. For orthotics and custom made shoes, please provide a description of how they are constructed.

_____

_____

_____

_____

7. Charges: (Please list **all** charges separately)

	TREATMENT RENDERED	DATE OF PICKUP YR	MO	DAY	CHARGES
1					
2					
3					
4					
5					
6					

Provider No. _____ Telephone No. _____

Provider Name _____ Designation _____

Address _____

City _____ Province _____ Postal Code _____

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

_____ _____

Signature of Provider Date

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above. I further certify that I have received the items listed herein and that they are in my possession.

_____ _____

Signature of Patient or Parent/Guardian Date

ASSIGNMENT OF BENEFITS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? ☐ YES ☐ NO

_____ _____

Signature of Patient or Parent/Guardian Date

IF PAYMENT IS TO BE MADE TO THE SUBSCRIBER ATTACH A PAID RECEIPT.