

## **AUTHORIZATION FORM FOR CUSTOM BRACES**

PO Box 1623, Windsor, Ontario N9A 7B3 Attn: EHS Department Customer Service Centre 1-888-711-1119 or (519) 739-1133 Fax (519) 739-0046 **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 preapproval may result in a denial of your claim.

Patie	nt's Name Date of Birth/ Age
Addr	ess Green Shield I.D. No
	Telephone No
	E-Mail Address
yes.	ou have any other Group Insurance coverage that may include these services as benefits? Yes No No notes and the provide Insurance Company name recoverage is Green Shield, indicate Green Shield number
SE(	CTION II - MUST BE COMPLETED IN FULL BY TREATING PHYSICIAN
	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:
	Condition of Patient: Acute Chronic
	Duration of Need: Weeks Months Year(s) Lifetime
	Diagnosis (Please be specific):
	Past Treatments: Physio# of Treatments Surgery Medications X-rays
	Degree of joint space: Past/Future Loss NA
·	Specify medically why a custom brace is necessary as opposed to a standard brace:
	Was brace shown to patient and costs provided? Yes $\square$ No $\square$
	Is the prescribed item a replacement? Yes $\square$ No $\square$ If Yes, give reason
0.	Has application been made for Government funding? Yes $\square$ No $\square$ If No, give reason
1.	Not Applicable ☐  Is the device(s) and/or medical equipment required:
1.	- As a result of a work related injury? Yes \( \sigma \) No \( \sigma \)
	- A motor vehicle accident? Yes \( \subseteq \text{No } \subseteq \)
	- For sports purposes only? Yes ☐ No ☐
	Date
nysici	ian's Signature
hysici	ian's Name (Please Print) Physician's Telephone Number
rovid	aing 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 ed by me to Green Shield Canada for claims adjudication and any other services necessary in the stration of our benefits which may include the exchange of information with other parties to administer this benefit claim.
	uthorized 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 s

**KNEEB**