MANITOBA BLUE CROSS®

ORTHOTICS, ORTHOPEDIC SHOES, AND MODIFICATIONS CLAIM FORM

SERVICE RECIPIENT INFORMATION			Is this: A Pre-Authorization ☐ A Claim ☐
Certificate Number	Group Number 7654		Has your address changed? Yes ☐ No ☐
Last Name	First Name		
Address			Are any expenses the result of an accident? Yes ☐ No ☐ If Yes, please complete the following:
City	Province	Postal Code	Where did the accident occur? Work ☐ Vehicle ☐ Other ☐ _____
Email Address	Telephone Number		

PRESCRIPTION AND DIAGNOSIS - MUST BE COMPLETED BY THE MEDICAL PRESCRIBER

1. Diagnosis (please be specific)

2. Footwear required ☐ Shoes ☐ Orthotics ☐ Both

Additional Details: _____

3. Are the items required for sports purposes only? ☐ Yes ☐ No

Name of Prescriber

Address

Professional Designation of Prescriber

Signature of Prescriber	Date (DD/MM/YYYY)

ORTHOPEDIC SHOES - CUSTOM-MADE/MODIFICATIONS - TO BE COMPLETED BY DISPENSING PROFESSIONAL

☐ Custom-made orthopedic shoes. Include a copy of the detailed lab invoice

☐ Prefabricated orthopedic shoes with modifications:

Name of shoes:

Detailed description of modifications:

CUSTOM-MADE ORTHOTICS - TO BE COMPLETED BY DISPENSING PROFESSIONAL

1. Are the orthotics: ☐ Stock ☐ Custom-Made (fabricated from raw materials)

If custom-made, please complete the following:

2. Identify the casting technique used to create the custom-made orthotics:

- ☐ Semi-weight bearing foam casting box
- ☐ Plaster of paris slipper cast
- ☐ 3D contact digitizing
- ☐ 3D laser imaging scanning
- ☐ Other (please specify) _____

CHARGES: (Please list all charges separately):		
Product/Treatment Description	Date received/Date of pickup (DD/MM/YYYY)	Amount Claimed ($)

DISPENSING PROVIDER INFORMATION			
Provider Name	Provider Number		
Provider Designation	Provider Telephone Number		
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 (DD/MM/YYYY)

ASSIGNMENT OF BENEFITS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? ☐ Yes ☐ No

Signature of Patient or Parent/Guardian

Date (DD/MM/YYYY)

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

AUTHORIZATION AND CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the 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 or personal health 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, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. 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 and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies or for questions as to the collection, use, or disclosure of my information, I may contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

A photostatic copy of this authorization shall be as valid as the original.

Signature of Patient or Parent/Guardian

Date (DD/MM/YYYY)