

PO Box 1623, Windsor, Ontario N9A 7B3
Attn: EHS Department
CUSTOMER SERVICE CENTRE
1-888-711-1119 or (519) 739-1133

**AUTHORIZATION FORM FOR
PROSTHETIC/ORTHOTIC DEVICES/MEDICAL EQUIPMENT/OXYGEN**

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

Patient's Name _____ Date of Birth ____/____/____ Age ____
Address _____ Green Shield No. _____
_____ 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 PHYSICIAN

1) I, as the attending Physician, hereby prescribe the following prosthetic/orthotic device(s) and / or medical equipment for the above named patient.
(Please include specifications when available.)

(A) _____

(B) _____

2) Condition of Patient: Acute _____ Chronic _____ Palliative _____

3) Duration of Need: _____ Weeks _____ Months _____ Year(s) _____ Lifetime

4) Diagnosis (PLEASE BE SPECIFIC): _____

5) For Hospital Beds only: Please indicate the hours or percentage of time in bed: _____

6) Is prescribed item a replacement? Yes _____ If yes, give reason _____ No _____

7) Has application been made for Government funding? Yes _____ No _____ If No, give reason _____
Not Applicable _____

8) 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 _____

FOR OXYGEN CLAIMS ONLY:

() concentrator (including back-up and portable cylinders) () cylinder (compressed oxygen for stationary and/or portability)

() liquid, reservoir and portable units (for high flow rates \geq 4 litres per minute or individuals mobilizing 3 hrs. daily, $>$ 3 times per week, preferably outside the home.)

Flow Rate (litres per minute) _____ Anticipated hours per use (each day) _____

Name of Oxygen Vendor (if available) _____

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READINGS WITH THIS REQUEST.

For Ontario Residents Only - Has application been made to the Ministry of Health for Funding?
_____ Yes _____ No - If No, please provide reason why application has not been made. _____

If application has been made and funding denied, please attach their denial letter.

Physician's Signature _____ () G.P. () Specialist Date _____

Physician's Phone Number _____

Physician's Name (Please Print) _____

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.**