# AUTHORIZATION FORM FOR PROSTHETIC APPLIANCES AND DURABLE MEDICAL EQUIPMENT

**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**
**Email: medical.authorization@greenshield.ca**

**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.** _____

**E-Mail Address** _____

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 THE PHYSICIAN

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

| | Estimated Cost (**required**) |
|---|---|
| (A) _____ | (A) _____ |
| (B) _____ | (B) _____ |
| (C) _____ | (C) _____ |
| (D) _____ | (D) _____ |
| (E) _____ | (E) _____ |

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) For Viscosupplementation only. Indicate left or right knee. Left ☐ Right ☐

7) For nutritional/feeding supplements only: Please indicate if this will be the patient's sole source of nutrition? Yes ☐ No ☐

8) For TENS only: Please indicate if patient is currently receiving chiropractic or physiotherapy treatments or both (within last 6 months)?
Chiropractor ☐ Physiotherapy ☐ Both ☐ Neither ☐

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

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

11) 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 ☐

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

_____ _____

**Physician's Name (Please print)** **Physician's Phone No.**

**By signing 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 provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.**

**I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.**

**ALL CLAIMS MUST BE RECEIVED BY GREEN SHIELD CANADA WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).**
**THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER**