Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta T6E 5R6
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Fax: (780) 465-0808 Email: claims@ebfa.ca

Supplementary Health Expense -
Orthopedic Boots/Shoes

Section 1 – To Be Completed By The Plan Member

Plan Policy Number: 6012

Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City/Province/Postal Code: Area Code and Telephone Number:

Birth Date (dd/mm/yy): Gender: ☐ Male ☐ Female

If The Claim Is On Behalf Of An Eligible Dependent, Please Complete The Following

Dependent's – Last Name, First Name and Initial: Date of Birth (dd/mm/yy):

Relationship (i.e. spouse, daughter, son):

Instructions

- **All Plan Members are encouraged to have their orthopedic boot/shoe claims preauthorized prior to purchase. Failure to do so may jeopardize payment of your claim**.
- Orthopedic boots/shoes are payable to a maximum of $1,200 per person every three calendar years.
- Orthopedic boots/shoes must be built from scratch and custom-made for the patient's feet. Retail footwear is not custom-made footwear. Retail footwear with the addition of a modification or custom foot orthotic does not qualify as orthopedic boots/shoes.
- Orthopedic boots/shoes must be prescribed with each claim form (Section 5).
- Claims for orthopedic boots/shoes cannot be assigned to the provider.
- A claim form must be completed for each Plan Member, Spouse or Dependent.
- The documentation stated in Section 6 must be submitted with each claim or preauthorization for orthopedic boots/shoes.
- An original paid receipt and proof of payment is required. See Section 4.
- Orthopedic boots/shoes can only be prescribed by a Medical Doctor/Specialist, Podiatrist, Chiropodist or OPQ.
- Orthopedic boots/shoes must be dispensed through the proper dispenser/provider (Section 6).
- The Fund Office reserves the right to request additional information required to process this claim.

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Section 2 – Co-Insurance Information

Do you or your dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form?
□ Yes □ No If yes, please provide:

Plan Member – Last Name, First Name and Initial: Date of Birth (dd/mm/yy):

Insurance Company: Address: Postal Code: Telephone Number: Policy Number:

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law? □ Yes □ No

Section 3 – Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the Insurer, Board of Trustees, Medical Consultant, or any of their authorized representatives for purposes of settlement of this claim, as well as for any review, investigative or administrative purposes.

Signature of Plan Member Date (dd/mm/yy)

Section 4 – Proof Of Payment

A) As proof of payment, I attach my **original paid receipt** showing the orthopedic boots/shoes have been paid in full **and** one of the following:

- ☐ *debit receipt*
- ☐ *credit card receipt*
- ☐ *cash register receipt*
- ☐ *credit card statement*
- ☐ *other* _____.

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Section 5 – To Be Completed By A Medical Doctor/Specialist, Podiatrist, Chiropodist, or OPQ (Quebec Only)

PRESCRIBER:

Prescriber's Last Name, First Name and Initial: _____

Address/City/Province: _____ Postal Code: _____ Area Code and Telephone Number: _____

B) Please check one of the following:

I am a:

- ☐ *Medical General Practitioner, or Specialist (M.D.)*
- ☐ *Podiatrist (DPM)*
- ☐ *Chiropodist (D CH or D Pod M)*
- ☐ *OPQ (Quebec Only)*

C) I prescribe the following medical item for _____:
Patient's Name (Last Name, First Name)

☐ *Custom-made orthopedic boot/shoe* ☐ *Other* _____

D) The appliance will be used for:

☐ *Daily Activity* ☐ *Sports Activities* ☐ *Daily Activities and Sports*

E) Diagnosis of medical condition (print clearly):

F) Symptoms/chief complaint (print clearly):

G) Comments:

_____
Signature of Physician Date (dd/mm/yy)

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Section 6 – To Be Completed By The Company Who Dispensed The Custom-Made Orthopedic Boots/Shoes

DISPENSER / PROVIDER :

H)

_____

Name of Company: Address: Postal Code: Telephone Number:

I) We are one of the following (place check mark and circle designation):

- ☐ *Medical General Practitioner, or Specialist (M.D.)*
- ☐ *Orthotists (CO (c), or CPO (c))*
- ☐ *Pedorthist* (C Ped (C), or C Ped MC)
- ☐ *Podiatrist* (DPM)
- ☐ *Chiropodist* (D CH or D Pod M)
- ☐ *Other* _____

J) Total Cost of Product: $_____

K) Signature: _____

L) Please attach the following documentation to this claim form.

- ☐ *A copy of the patient's gait analysis, and*
- ☐ *a copy of the patient's biomechanical examination results, and*
- ☐ *a description of how the custom-made orthopedic boots/shoes are made*