



Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808 Email: claims@ebfa.ca

Supplementary Health Expense - Orthotic Inserts

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 This 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

- Orthotic inserts are payable to a maximum of \$400 per person per calendar year.
- Orthotic inserts must be prescribed once every 5 years (Section 5).
- Claims for orthotic inserts cannot be assigned to the provider.
- A claim form must be completed for each Plan Member, Spouse or Dependent.
- Orthotic inserts can be preauthorized by the Fund Office prior to purchase.
- The documentation stated in Section 6 must be submitted with each claim for custom-made orthotic inserts.
- An original paid receipt and proof of payment is required. See Section 4.
- Orthotic inserts can only be prescribed by a Medical Doctor/Specialist, Podiatrist, Chiropodist or OPQ.
- 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 orthotic inserts 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) _____

Other _____

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

Off-the-shelf orthotic insert

Custom-made orthotic insert

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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Orthotic Inserts

Section 6 – Required Documentation

H) If custom-made orthotics have been prescribed, 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 orthotic inserts were made.*

****Please note: Your Gait Analysis and Biomechanical Examination Results must be Signed and Dated by the individual who performed them.***
