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 -
Orthotic Inserts

Section 1 – To Be Completed By The Plan Member

Policy Number: **6012**

Plan Member – Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City: Province: Postal Code: Telephone Number:

Cell Number: Birth date (dd/mm/yy): Gender: ☐ Male ☐ Female

Claimant Information:

Patient Name:	Date of Birth (dd/mm/yy):	Relationship to Plan Member:

Coordination of Benefits:

Do you or your dependents have any other coverage for the expenses being claimed on this form?
□ **Yes** □ **No** **If yes, please provide:**

Name of Insured: _____ Name of Insurance Company: _____

Date of birth (dd/mm/yy): _____ Plan Policy Number: _____

Plan Member ID Number: _____ Plan Effective Date: _____

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

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 6) by a Medical Doctor/Specialist, Podiatrist, Chiropodist, or OPQ.
- Claims for orthotic inserts cannot be assigned to the provider.
- A claim form must be completed for each Plan Member, Spouse or Dependent.
- An original paid receipt and proof of payment is required. See Section 4.
- The documentation stated in Section 5 must be submitted with each claim for custom-made orthotic inserts.
- A co-insurance statement of payment or denial (if applicable)
- Orthotic inserts can be preauthorized by the Fund Office prior to purchase.
- The Fund Office reserves the right to request additional information required to process this claim.

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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 Plan Administrator, 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 **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* _____.

Section 5 – 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 biomechanical gait analysis, and*
- ☐ *a description of how the orthotic inserts were made, including casting technique.*

**Please note: Your Gait Analysis and Biomechanical Examination Results must contain the date of the exam and the name and designation of the examiner. A biomechanical gait analysis is not required if the orthotic inserts were prescribed by a podiatrist or chiropodist.*

_____

_____

_____

_____

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Section 6 – 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)* ☐ *OPQ (Quebec only)* _____

☐ *Chiropodist (D CH or D Pod M)* ☐ *Other*_____

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

☐ *Off-the-shelf orthotic insert(s)* ☐ *Custom-made orthotic insert(s)*

D) The appliance will be used for (check applicable):

☐ *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)