P. O. BOX 1623
Windsor, Ontario N9A 7B3
Attn: Group Benefit Services
Group Customer Service: 1.800.665.7076 | Website: wawanesalife.com

CLAIM FORM FOR CUSTOM FOOT ORTHOTICS/FOOTWEAR

To the Patient: The details requested below are mandatory in order for Wawanesa Life to determine our liability with respect to this request.

PROVIDER		PATIENT	
Provider No.	Telephone No. ( )	WLI number	Date of Birth ___ / ___ / ___
Name		Name	
Street Address		Address	
City Province Postal Code		City Province Postal Code	

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 Wawanesa Life, indicate WLI number _____

THIS SECTION MUST BE COMPLETED IN FULL BY THE DISPENSING AND/OR TREATING PHYSICIAN / CHIROPODIST / PODIATRIST / CHIROPRACTOR / PEDORTHIST / ORTHOTIST.

1. I hereby prescribe/provide the following for the above named patient: ☐ Custom Foot Orthotics ☐ Custom-made Orthopedic Shoes
2. Diagnosis (please be specific):_____
3. Are the device(s) 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 ☐

If the Claim is for Custom Foot Orthotics, the following is also required:

1. Copy of diagnostic measures test results:
   ☐ Biomechanical Examination or ☐ Gait Analysis ☐ Other_____
2. Identify casting technique. Must create 3D volumetric model of patient's foot.
   ☐ Subtalar Neutral Cast(i.e. Plaster of Paris) ☐ Semi-Weight Bearing Cast (i.e. Foam Cast)
   ☐ 3D Laser Scan ☐ Other, please indicate_____
3. Copy of the lab invoice showing the raw materials used to construct the orthotic and the costs associated/ incurred in the manufacturing process.

The prescriber must sign in this box or attach the prescription.

_____ **Date**_____

Name of Physician / Chiropodist / Podiatrist (Please Print)

☐ **Physician** ☐ **Chiropodist** ☐ **Podiatrist** ☐ **Other** _____

Signature_____ **Phone No. (_____)** _____

	TREATMENT DESCRIPTION	DATE OF PICKUP YR	MO	DAY	CHARGES $
1.					$
2.					$
3.					$

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

_____ _____ _____
Signature of Provider **Accreditation** **Registered No.**

THE PLAN MEMBER HAS PAID THE CHARGES LISTED ON THIS CLAIM IN FULL. PLEASE REIMBURSE PLAN MEMBER DIRECTLY.

_____
Signature of Provider

I certify that the orthotics have been picked up and are in my possession and hereby authorize payment directly to the provider named above.

_____
Signature of Patient **Date**

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.
By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Wawanesa Life about myself and my dependents, will be used by Wawanesa Life 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 further authorize Wawanesa Life to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

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