



**Plan Administration
Office Address**
 45 McIntosh Drive
 Markham, ON L3R 8C7
 Phone: 1-800-668-7547 Fax: 1-905-946-2535
 E-Mail: medical@boilermakersbenefits.ca

REQUEST FORM FOR CUSTOM BRACES

BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

All Claims must be submitted within 12 months of the date of service. The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

PATIENT INFORMATION (MUST BE COMPLETED BY THE PATIENT OR GUARDIAN)			
BOILERMAKERS' BENEFIT CARD ID NUMBER	MEMBER'S NAME	MEMBER'S SOCIAL INSURANCE NUMBER	
LAST NAME OF PATIENT	FIRST NAME OF PATIENT	PATIENT'S DATE OF BIRTH	
RELATIONSHIP TO PLAN MEMBER (IF DEPENDANT)	MEMBER'S E-MAIL ADDRESS	MEMBER'S TELEPHONE NUMBER	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE
DOES THE PATIENT HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF "YES", PLEASE PROVIDE INSURANCE COMPANY NAME: _____			

PHYSICIAN INFORMATION (MUST BE COMPLETED BY THE ATTENDING PHYSICIAN)	
I, as the attending Physician, hereby prescribe the following custom brace(s) for the above named patient. (Please include specifications when available)	
A) TYPE OF BRACE: _____	
B) LEFT: _____ RIGHT: _____ BILATERAL: _____	
C) ESTIMATED COST: _____	
CONDITION OF PATIENT: ACUTE: _____ CHRONIC: _____	
DURATION OF NEED: WEEK(S): _____ MONTH(S): _____ YEAR(S): _____ LIFETIME: _____	
DIAGNOSIS (PLEASE BE SPECIFIC): _____	
PAST TREATMENT: PHYSIOTHERAPY: _____ # OF TREATMENTS: _____ SURGERY: _____ MEDICATIONS: _____ X-RAYS: _____	
DEGREE OF JOINT SPACE: PAST/FUTURE LOSS: _____ N/A: _____	
SPECIFICALLY MEDICALLY WHY A CUSTOM BRACE IS NECESSARY AS OPPOSED TO A STANDARD BRACE: _____	
WAS BRACE SHOWN TO PATIENT AND COSTS PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS PRESCRIBED ITEM A REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE REASON: _____	
HAS APPLICATION BEEN MADE FOR GOVERNMENT FUNDING? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE IF "NO", GIVE REASON: _____	
IS THE DEVICE(S) AND/OR MEDICAL EQUIPMENT REQUIRED: AS A RESULT OF A WORK RELATED INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
AS A RESULT OF A MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOR SPORTS PURPOSES ONLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PHYSICIAN'S SIGNATURE

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____

PHYSICIAN'S TELEPHONE NUMBER: _____

DATE: _____

MAILING INSTRUCTIONS (ONCE COMPLETED, PLEASE RETURN ALONG WITH ANY ORIGINAL PAID RECEIPTS TO):**ADDRESS:**

Boilermakers' National Benefit Plans (Canada) Administration Office
 45 McIntosh Drive
 Markham, Ontario, L3R 8C7

TELEPHONE NUMBER:

1-905-946-2530 or 1-800-668-7547

FAX NUMBER:

1-905-946-2535

E-MAIL ADDRESS:

MEDICAL@BOILERMAKERSBENEFITS.CA

Privacy Statement: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal information will be protected pursuant to applicable legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, unions, regulators, legal counsel, actuaries etc.) in order to manage the Plan and your entitlement to the Benefits of the Plan.

Questions related to the Privacy Policy of the Plan should be direct to the Plan Administration Office at 1-800-668-7547

Rev Date: 11/03/2014