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 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? ☐ YES ☐ 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? ☐ **YES** ☐ **NO**

IS PRESCRIBED ITEM A REPLACEMENT? ☐ **YES** ☐ **NO** IF "YES", GIVE REASON: _____

HAS APPLICATION BEEN MADE FOR GOVERNMENT FUNDING? ☐ **YES** ☐ **NO** ☐ **NOT APPLICIABLE**
IF "NO", GIVE REASON: _____

IS THE DEVICE(S) AND/OR MEDICAL EQUIPIMENT 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**

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