



**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 PROSTHETIC APPLIANCES AND DURABLE MEDICAL EQUIPMENT COVERAGE

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 FULL NAME	MEMBER'S SOCIAL INSURANCE NUMBER	
LAST NAME OF PATIENT	FIRST NAME OF PATIENT	PATIENT'S DATE OF BIRTH	PATIENT'S AGE
RELATIONSHIP TO PLAN MEMBER (IF DEPENDANT)	MEMBER'S E-MAIL ADDRESS	MEMBER'S TELEPHONE NUMBER	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE
DO YOU 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 prosthetic appliance(s) and/or medical equipment for the above named patient. <small>(Please include specifications when available)</small>	
A) _____	ESTIMATED COST (required) A) _____
B) _____	B) _____
C) _____	C) _____
D) _____	D) _____
E) _____	E) _____
CONDITION OF PATIENT: ACUTE _____ CHRONIC: _____ PALLIATIVE: _____	
DURATION OF NEED: _____ WEEKS _____ MONTHS _____ YEAR(S) LIFETIME _____	
DIAGNOSIS (PLEASE BE SPECIFIC): _____	
FOR HOSPITAL BEDS ONLY - PLEASE INDICATE THE HOURS OR PERCENTAGE (%) OF TIME IN BED: _____	
FOR VISCOSUPPLEMENTATION ONLY - INDICATE LEFT OR RIGHT KNEE: <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	
FOR NUTRITIONAL/FEEDING SUPPLEMENTS ONLY - PLEASE INDICATE IF THIS WILL BE THE PATIENT'S SOLE SOURCE OF NUTRITION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOR TENS ONLY - PLEASE INDICATE IF PATIENT IS CURRENTLY RECEIVING CHIROPRACTIC OR PHYSIOTHERAPY TREATMENTS OR BOTH (WITHIN THE LAST 6 MONTHS): <input type="checkbox"/> CHIROPRACTOR <input type="checkbox"/> PHYSIOTHERAPY <input type="checkbox"/> BOTH <input type="checkbox"/> NEITHER	
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: _____

 G.P. SPECIALIST

PHYSICIAN'S NAME (PLEASE PRINT): _____

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