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? ☐ YES ☐ NO
IF "YES", PLEAE 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.
(Please include specifications when available)

		ESTIMATED COST (required)
A)	_____	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: ☐ **LEFT** ☐ **RIGHT**

FOR NUTRITIONAL/FEEDING SUPPLEMENTS ONLY – PLEASE INDICATE IF THIS WILL BE THE PATIENT'S SOLE SOURCE OF NUTRITION: ☐ **YES** ☐ **NO**

FOR TENS ONLY – PLEASE INDICATE IF PATIENT IS CURRENTLY RECEIVING CHIROPRACTIC OR PHYSIOTHERAPY TREATEMENTS OR BOTH (WITHIN THE LAST 6 MONTHS):

☐ **CHIROPRACTOR** ☐ **PHYSIOTHERAPY** ☐ **BOTH** ☐ **NEITHER**

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 EQUIPMENT 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: _____ ☐ **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