



## PARAMEDICAL SERVICES APPROVAL REQUEST FORM

Claims for paramedical services after the first \$150 per type of practitioner per person (per year) must be approved for reimbursement under your Health Plus™ insurance plan.

We recommend this form be completed in full and submitted to Beneplan Inc. *before* services are performed. Lack of pre-approval for treatment could result in your claim not being paid.

### TYPE OF PARAMEDICAL SERVICES YOU ARE REQUESTING APPROVAL FOR:

- Acupuncture
- Chiropractic
- Clinical Psychology
- Massage Therapy
- Naturopathy
- Osteopathy
- Physiotherapy
- Speech Therapy

Please submit completed form prior to any paramedical services being rendered to

Paramedical Claims  
**Beneplan Inc.**  
500-150 Ferrand Drive  
Toronto, ON M3C 3E5

### PLAN MEMBER INFORMATION

Plan Member: \_\_\_\_\_

Health Plus™ ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Address: \_\_\_\_\_

Tel #: \_\_\_\_\_ E-mail: \_\_\_\_\_

This claim is for:  Self  Dependent

Name of Dependent: \_\_\_\_\_

Dependent Date of Birth: \_\_\_\_\_

Dependent Health Plus™ ID#: \_\_\_\_\_

Please state the reason you or your dependent require paramedical services to be rendered:

\_\_\_\_\_  
\_\_\_\_\_

Who recommended the treatment you seek and why?

\_\_\_\_\_  
\_\_\_\_\_

I certify that the above statements are true. I hereby authorize any licensed physician, medical practitioner, hospital or any facility or related person that has any medical information relevant to this claim to release such information as requested by Beneplan.

Plan Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**ATTENDING PHYSICIAN STATEMENT**

(Please print)

Patient Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Diagnosis of present condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_Treatment recommended:  
\_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge, when did the claimant's symptoms first appear? \_\_\_\_\_

Did you recommend the treatment or was the treatment requested by the claimant?  
\_\_\_\_\_

I certify that the above statements are true. I understand that any charges for completing this form are the claimant's responsibility. Note: Additional information may be requested.

**Attending Physician Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_

Physician stamp: \_\_\_\_\_

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**ATTENDING PARAMEDICAL PRACTITIONER STATEMENT**

(Please print)

Paramedical Practitioner Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel #: \_\_\_\_\_ Official Registered Therapist #: \_\_\_\_\_

Diagnosis, recommended treatment(s), number of visits required and fee per visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above statements are true. I understand that before rendering any services to this patient this claim (treatment) should be "pre-approved" by the Administrator (Beneplan) and that any claims that are not pre-approved may be declined. Any charges for completing this form are the claimant's responsibility.

**Attending Paramedical Practitioner Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_

Beneplan Approval (amount, # of visits, etc) _____
Beneplan Authorized Signature: _____