PARAMEDICAL SERVICES APPROVAL REQUEST FORM

Claims for paramedical services after the first $250 per type of practitioner per person to a combined maximum of $600 per person per year (PRIORITY) or $300 per practitioner per person to a combined maximum of $750 per person per year (OPTIMUM) must be approved for reimbursement under your Health Plus insurance plan. We recommend this form be completed in full and submitted to Health Plus *before* services are performed. Lack of pre-approval for treatment could result in your claim not being paid.

Please Note: If requesting multiple types of services, a paramedical practitioner statement must be provided for each requested service. Requests submitted without the required statements will be considered incomplete and cannot be processed.

TYPE OF PARAMEDICAL SERVICES YOU ARE REQUESTING APPROVAL FOR:

- ☐ Acupuncture
- ☐ Chiropodist/Podiatry
- ☐ Chiropractic
- ☐ Naturopathy
- ☐ Osteopathy
- ☐ Physiotherapy
- ☐ Speech Therapy
- ☐ Massage Therapy

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

Health Plus™ Insurance
Paramedical Claims
20-390 Wellesley St. East
Toronto, ON M4X 1H6
Email: claims@healthplusinsurance.ca

PLAN MEMBER INFORMATION

Plan Member: _____

Health Plus™ ID#: _____ Date of Birth: _____

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 Health Plus™ Insurance.

Plan Member Signature: _____ **Date:** _____

ATTENDING PHYSICIAN STATEMENT- MUST BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER (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:

ATTENDING PARAMEDICAL PRACTITIONER STATEMENT (Please print)

Requested Paramedical Service: _____

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 (Health Plus™) 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: _____

Health Plus™ Approval (amount, # of visits, etc.): _____

Health Plus™ Authorized Signature: _____

ATTENDING PARAMEDICAL PRACTITIONER STATEMENT (Please print)

Requested Paramedical Service: _____

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 (Health Plus™) 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: _____

Health Plus™ Approval (amount, # of visits, etc.): _____

Health Plus™ Authorized Signature: _____