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.

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?

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____

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 (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)

Paramedical Practitioner Name: ________________________________

Address: ____

Tel #: ______________________ Official Registered Therapist #: ____________

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

____

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____

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: ______________________________________