



PARAMEDICAL CLAIM FORM (Pre Approval Required)

This form should be used for covered Paramedical services namely Physiotherapy, Speech Therapy and Clinical Psychology, Acupuncture, Chiropractor, Osteopath, Podiatrist, Naturopath, and Massage Therapist. This form *must be completed and submitted to Beneplan (address below) prior to any services being performed. Paramedical services must be "Pre Approved" by Beneplan, failure to have "Pre Approval" could result in the claim not being paid.* Please ensure that this form is completed as clearly as possible.

Please indicate what type of Paramedical coverage you are claiming:

- Acupuncture Chiropracist/Podiatry Chiropractic Clinical Psychology Massage Therapy
Naturopathy Osteopathy Physiotherapy Speech Therapy Compression Hose Orthotics/Shoes

Please submit completed form prior to any paramedical services being rendered to
**Paramedical Claims - Beneplan Inc, 150 Ferrand Dr. Suite 500, Toronto,
Ontario M3C 3E5 / paramedicals@beneplan.ca / Fax 416-863-5157**

Plan Member's Information

Plan Member Name: _____
Home Address: _____
Company Name: _____ Policy #: _____
Certificate #: _____ Employee Tel #: (____) _____
Employee Date of Birth: _____ Gender: _____
Is this claim for you or your Dependent? _____

Name of Dependent: _____ Dependent Date of Birth _____

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 as administrator for my employer.

Employee's Signature: _____ **Date:** _____

Attending Physician Statement Section

Employee (Patient) Name (please print): _____

Employee (Patient) Signature: _____ Date: _____

Attending Physician Name: _____

Attending Physician Address: _____

Attending Physician Tel #: (____) _____ Fax #: (____) _____

Diagnosis of present condition:

To the best of your knowledge when did the claimant's symptoms first appear? _____

What treatments do you recommend?

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: _____

Attending Paramedical Practitioner Statement

Name of Paramedical Practitioner: _____

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) must be "Pre - Approved" by the Administrator (Beneplan). Any claims that are not Pre - Approved can be declined. Any charges for completing this form are the claimant's responsibility.

Attending Paramedical Signature: _____ Date: _____

Beneplan Approval (amounts, # of visits etc): _____

Beneplan Authorized Signature: _____
