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 ☐ Chiropodist/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: ____