MEDAVIE BLUE CROSS™

This summary will assist us to adjudicate the claim and provide timely reimbursement.

Please provide the information below and submit with the paid in full receipt and other supporting documentation.

Patient Name: _____

ID Number: _____ Policy Number: _____

The below sections to be completed by the provider of service.

PROVIDER INFORMATION

Provider Name: _____

Speciality Type: _____ Provider Number: _____

PRESCRIPTION AND DIAGNOSIS

A copy of the prescription must be attached.   Please indicate the prescriber type (ie. MD, Podiatrist etc): _____

Patient Diagnosis: _____

ORTHOPEDIC SHOES

❑ **Custom-made Orthopedic Shoes:** *Include a copy of the detailed lab invoice*

❑ **Pre-fabricated Orthopedic shoes with modifications:** *Complete the below information, and include the detailed invoice/receipt.*

Make and Model number of the shoe: _____   Cost of Shoe: $ _____

Did the shoes receive **Major Permanent Modifications**?	Did the shoes receive **Minor Alterations**?
❑ Yes ❑ No	❑ Yes ❑ No
If yes, list the specific modification, with the cost of each:	If yes, list the specific modification, with the cost of each:
_____ $ _____	_____ $ _____
_____ $ _____	_____ $ _____
_____ $ _____	_____ $ _____
Note: Medavie Blue Cross does not consider stretching, or pads/inserts glued into a shoes as an eligible permanent modification.	

A copy of the Gait Analysis or Biomechanical Assessment must be attached.

CUSTOM-MADE ORTHOTICS

Indicate the casting technique used to create the custom-made orthotics:

❑ Direct mold   ❑ Wax mold   ❑ Plaster of paris slipper cast   ❑ Semi-weight bearing foam casting box
❑ 3-D contact digitizing (ie pin array system)   ❑ 3-D laser imaging scanning

❑ Other (please specify) _____

Total cost of the Orthotics: $ _____

PROVIDER SIGNATURE

Signature of Provider: _____

Date: _____

MEDAVIE BLUE CROSS ADDRESSES

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