

**Instructions for completion**

This form must be completed in full to avoid delay in assessing the claim. Once we have all the required information and have assessed the information, we will notify the claimant, in writing, regarding plan coverage. Please ensure all fields are completed in pen using blue ink.

**Part 1: Patient Information (to be completed in full by the claimant)**

Patient name \_\_\_\_\_ Date of Birth: (dd/mm/yyyy) \_\_\_\_\_

Phone number: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Group Number \_\_\_\_\_ Certificate Number \_\_\_\_\_

Email Address \_\_\_\_\_

Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan?

Yes  No  if yes, what is the name of the other insurance agency?**Part 2: Provincial Funding (to be completed in full by claimant)**

Coverage for wheelchair benefits through your ClaimSecure plan are supplemental to any services you are entitled to through your provincial assistive devices program.

Please be sure to contact your provincial plan to verify eligibility before applying for wheelchair benefits with ClaimSecure.

Will a portion be covered by the provincial plan? Yes  No *If no please indicate the reason why?* \_\_\_\_\_**Part 3: Name of Prescribing Physician**

Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: (\_\_\_\_) \_\_\_\_\_ Fax number: (\_\_\_\_) \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**Part 4: Current Medical Information to be completed in full by physician**

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Prognosis: \_\_\_\_\_  
\_\_\_\_\_

Condition: Acute       Chronic       Palliative

If recommending electric or power wheelchair, please indicate reason why?

\_\_\_\_\_  
\_\_\_\_\_

Length of time wheelchair will be required:

\_\_\_\_\_

**Part 5: Purchase and rental information to be completed by the supplier**

Name of medical provider: \_\_\_\_\_

Brand Name \_\_\_\_\_

Model Number \_\_\_\_\_

Rental Cost: \_\_\_\_\_      Purchase cost: \_\_\_\_\_

\*please attach a breakdown of costs and a copy of provincial plan application if applicable\*

**Part 6: Authorization to be completed by the claimant**

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. If I am submitting personal information about myself and/or my spouse and/or dependents, I acknowledge that I/he/she/we/they have reviewed and consent to the Disclaimer and Privacy Policy (<https://www.claimsecure.com/privacy/>). I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan. I understand and agree that ClaimSecure will conduct audits of claims submitted by me for purposes including, but not limited to, preventing and detecting fraud. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose this claim, or any personal information contained in this claim, to the benefit plan sponsor/employer for the purposes of reporting fraud suspicious claims. I am aware that under certain circumstances permitted by law, ClaimSecure, or persons acting on its behalf, may be required or permitted to disclose this claim, and the information contained in this claim, including personal information, to others without my knowledge or consent, or the consent of the individual to whom the information relates. In all other circumstances, ClaimSecure will only disclose such personal information in accordance with ClaimSecure's Privacy Policy (<https://www.claimsecure.com/privacy/>). We may revise this Disclaimer from time to time, and will post the most current version on our website at <https://www.claimsecure.com/>. Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Disclaimer. We will indicate at the top of the page the date this Disclaimer was last revised. Your continued use of our services after any such changes constitutes your acceptance of the Disclaimer as revised.

Plan member name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please complete and return with supporting documentation:**

ClaimSecure, P.O. Box 6500 Station "A", Sudbury, Ontario P3A 5N5

Fax: 1-866-613-0530

Email: [service@claimsecure.com](mailto:service@claimsecure.com)

\*\*\*Note: Do not staple or tape receipts to the claim form\*\*

