beneplan

500-150 Ferrand Drive · Toronto · ON · M3C 3E5
Tel: 416-863-6718 · Fax: 416-863-5157 · Toll free: 1-800-387-1670
claims@beneplan.ca| www.beneplan.ca

Paramedical Pre-Approval Request Form

This form must be completed and submitted to Beneplan prior to services performed and incurring expenses, subject to plan conditions. Please refer to your booklet for conditions that may be specific to your plan.
Failure to have "Pre-Approval" as required by your plan, could result in the claim not being paid.
Please ensure that this form is completed as fully and clearly as possible.

Please indicate for what type of Paramedical coverage you are requesting pre-approval:

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

Plan Member Information

Plan Member Name: _____

Home Address: _____

Personal Email Address: _____
(Please, do not use your work email 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

(To Be Completed By The Patient's Medical Doctor or Nurse Practitioner)

Employee (Patient) Name (please print): _____

Employee (Patient) Signature: _____ Date: _____

Attending Physician Name: _____ CPSO License: _____

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?

Name of Paramedical Practitioner: _____

Tel #: (___)_____ Official Registered Therapist #: _____

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**: _____

Please submit completed form prior to any paramedical services to:

500-150 Ferrand Drive · Toronto · ON · M3C 3E5

Fax: 416-863-5157

claims@beneplan.ca