ORTHOTICS PREAUTHORIZATION / CLAIM FORM

Department of Families
Provincial Services
Health Services Programs
100-114 Garry St.
Winnipeg, MB R3C 4V4

Phone: (204) 945-5530
Fax: (204) 945-3930

Manitoba

1. Provider

Vendor Number:	Please circle one of the below: Podiatrist Pedorthist Orthotist Shoe provider
Name:	
Address:	
Phone:	Fax:
Providers Signature:_____ I certify that the treatment below was performed and all the information on this form is accurate.	

Patient

Certificate #	Birth date: Day/Month/Year
Last name:	First Name:
Address: Patient's Signature:_____ I authorize release of the information contained in this claim to Family Services and Consumer Affairs.	

2. Client Health Information

Item Requested: (Please attach Rx from Physician or Podiatrist)
Description: Please provide a full description of the item. For shoes that were modified, provide a detailed description of the shoe itself and the modifications performed. For orthotics and custom made shoes, please provide a description of how they are constructed.
Is any portion of this claim covered under any other public or private health care plan? Yes ☐ No ☐ If yes, name of insurer _____

3. Claim Detail

Date of Pickup	Description of Item	Fee
		Total:

4. Prior Approval (To be completed by Provincial Services Staff)

The above Treatment Plan is : **Approved** ☐ **Not Approved** ☐

More information required:

Authorization: # _____	Signature of H.S. Official:_____ Date:_____ Prescription reviewed on: _____