## SOCIAL DEVELOPMENT

Health Services Program
P.O. Box 5500, Fredericton, N.B., E3B 5G4
Toll Free: 1-844-551-3015
Fax: (506) 453-3960



## DÉVELOPPEMENT SOCIAL

Programme des services de santé C.P. 5500, Fredericton N.-B., E3B 5G4 Sans frais: 1-844-551-3015 Télécopieur: (506) 453-3960

FOOTWEAR AND ORTHOTICS APPLICATION FORM											
			С	LIENT INF							
	Last Name		First Name				Health Card Number				
Address							Date of Birth				
							DD	мм		YYYY	
Private Ins	surance Coverag	e □ Yes □ No				Amount of 3 <sup>rd</sup> I					
SERVICE PROVIDER											
Service Provider Service Provider ID # Email Address											
	Α	ddress		Fax Number			Certified Orthopedic Professional				
	-			T ax Numbe					рошо		
Certification Designation						Certification # if applicable)					
Certified o		+				Client					
profession	nal's Signature					Diagnosis					
	physician or					Rx Date					
nurse practitioner  NON-CUSTOM (STOCK) ORTHOPEDIC FOOTWEAR											
Retail		Client Participation Fee Health									
Cost		(10%	(10% or \$20.00 max)				Service	Services Cost			
Make		Model			Size		Style				
Applicable Criteria #'s Met (Refer to Policy) Warrant							ty Info	rmation			
Justification	on for criteria no	t met and	or Addit	tional Infor	mation						
_			0110								
Applicable	Critoria #'s Mot	(Pofor to		TOM MAL	DE FC	OTWEAR		Warran	tv Info	rmation	
Applicable Criteria #'s Met (Refer to Policy)							Warranty Information				
Justification for criteria not met and/or Additional Information											
CUSTOM FOOT ORTHOTICS											
☐ Left ☐ Right ☐ Bilateral Warranty Information											
Applicable Criteria #'s Met (Refer to Policy)											
				-							
Justification	on for criteria no	t met and	or Addit	tional Infori	mation	l					
I											

CLIENT NAME:			ı	HEALTH CARD #:						
	REPAIRS A	AND AD	JUSTMEN	TS TO S	HOES	AND F	от оі	RTHOTICS		
☐ Non-custom footwear			☐ Custom footwear			n foot or	thotics	Warranty Information		
☐ Repair ☐ Adjustment		ent	: □ Left		☐ Right		☐ Bilat	teral		
Age of Item:	(i	Make if applicable)			_	Model (if applicable)				
Applicable	Criteria #'s Met (	(Refer to P	olicy)			<u> </u>				
-	n of Adjustments									
Justification	on for criteria not	met and/c	or Additional In	formation						
MODIFICATIONS TO SHOES AND FOOT ORTHOTICS										
☐ Non-cu	stom footwear	☐ Custor	n footwear	☐ Custon	n foot o	rthotics		Warranty Information		
□ Left	☐ Right		☐ Bilateral							
Age of Item:	(i	Make if applicable)				odel licable)				
Applicable	Criteria #'s Met (	(Refer to P	olicy)			·				
Description	n of Modification	s								
Justification	on for criteria not	met and/c	or Additional In	formation						
ATTACHMENTS										
☐ Physician's prescription ☐ Quote on Health				ervices inv	/ices invoice ☐ Statement of Bene			Benefits (private insurance only)		