EAST HILLS PHYSIOTHERAPY

Unit 303, 409 East hills Blvd. SE
Calgary, AB ,T2A 4X

DIRECT ELECTRONIC CLAIM SUBMISSION AUTHORIZATION

Patient Name: _____ **Date of Birth (MM/DD/YYYY):** _____

Name of the **Primary** Insurance Company: _____

Primary Policy Holder Name: _____ Date of Birth (MM/DD/YYYY): _____

Policy ID/Claim #: _____ Group ID: _____

Do you have any other/secondary Extended Health Benefit? _____

Name of the **Secondary** Insurance Company: _____

Secondary Policy Holder Name: _____ Date of Birth (MM/DD/YYYY): _____

Policy ID/Claim #: _____ Group ID: _____

Assignment of Benefits Needed? Yes / No

Coverage Period Start: _____ End: _____

Physiotherapy Coverage:
Max Limit: $_____ Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name_____ Date of Referral_____

Massage Coverage:
Max amount Limit: $_____ Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name_____ Date of Referral_____

Custom Foot Orthotics:
Max amount Limit: $_____ Percentage covered each Year: _____ Deductibles: _____

Doctor's referral provided for Custom foot Orthotics? Yes / No

If Yes, Physicians Name_____ Date of Referral_____

Did you apply for Custom foot orthotics earlier to your Insurance? Yes/No

- If Yes, Please provide the date of Service_____

CONSENT

- **I hereby certify that East Hills Physiotherapy Centre has been authorized to submit claims on my behalf to my Insurance Company and the information contained in the claims is complete and accurate.**
- **I am responsible to pay the co-payment, if applicable, at the time of each appointment.**
- **I understand that I am fully responsible to make full payment, if my insurance company denies my claim**

Signature: _____ **Date:** _____