INTELLIGENT HEALTH GROUP

Patient Name: _____

EXTENDED HEALTH CARE COVERAGE FORM

Insurance Company Name	Plan/Policy #	Group/ID #	What is the Benefit Year?
Telephone #		Fax #	
Policy Holder Name		Policy Holder Date of Birth (YYYY/MM/DD)	

CHIROPRACTIC
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

PHYSIOTHERAPY
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

MASSAGE THERAPY
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

ACUPUNCTURE
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Covered if TCM completes? ☐Yes ☐No
Additional Notes:

NATUROPATH
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

DIETICIAN
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Reasonable and necessary per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

PSYCHOLOGICAL COUNSELING
Maximum ($) coverage per benefit year? _____
% of coverage per visit? _____
Medical doctors referral needed? ☐Yes ☐No
Who can provide service?
☐ Social Worker: if yes, Reasonable and necessary per visit? _____
☐ Psychologist: if yes, Reasonable and necessary per visit? _____
☐ Psychiatrist: if yes, Reasonable and necessary per visit? _____
☐ Counsellor: if yes, Reasonable and necessary per visit? _____

INTELLIGENT HEALTH GROUP

Patient Name: _____

CUSTOM ORTHOTICS

Maximum ($) coverage per benefit year? _____
% of coverage per pair? _____
What is the eligibility for pair renewal?

- ❑ 1 per year
- ❑ 1 per 2 years
- ❑ 1 per 3 years
- ❑ Other: _____

Who can refer?

- ❑ Medical doctor
- ❑ Podiatrist
- ❑ Chiropodist
- ❑ Chiropractor

Can it be dispensed by a chiropractor?

What is required for claim submission?

- ❑ 3D Scan
- ❑ 2D Scan
- ❑ Biomechanical Analysis & Gait Analysis
- ❑ Casting Technique
- ❑ Raw Materials

Additional Notes:

COMPRESSION STOCKINGS

Maximum ($) coverage per benefit year? _____
% of coverage per pair? _____
Reasonable and necessary per pair? _____
How many pairs per year? _____
What is the compression factor eligible for reimbursement? (e.g. 20-30 mmHg) _____
Medical doctors referral needed?

- ❑ Yes
- ❑ No

Additional Notes:

TENS MACHINE

Maximum ($) coverage per benefit year? _____
% of coverage for device? _____
Reasonable and necessary for device? _____
Medical doctors referral needed?

- ❑ Yes
- ❑ No

Does the condition need to be chronic?

- ❑ Yes
- ❑ No

Additional Notes:

ORTHOPAEDIC BRACES (BACK, WRIST, KNEE, ELBOW, ANKLE)

Maximum ($) coverage per benefit year? _____
% of coverage per brace? _____
Reasonable and necessary per brace? _____
Medical doctors referral needed?

- ❑ Yes
- ❑ No

Additional Notes:

PILLOW

Maximum ($) coverage per benefit year? _____
% of coverage per pillow? _____
Reasonable and necessary per pillow? _____
Medical doctors referral needed?

- ❑ Yes
- ❑ No

Additional Notes:

I confirm that all the information above is accurate and that I have advised the clinic if any amount was used at another clinic in the current benefit year. It is my responsibility to make sure the amount of coverage being used is within my policy limit and that if the extended healthcare company does not pay for any visits, the payments are to be made by me directly to Intelligent Health Group for the services rendered and/or products and devices provided.

Patient Signature: _____ **Date: _____**