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

ORTHOSE	S & ORTI					PLICA	ATION	FORM	
		C	LIENT		RMATION	_			
Last N	ame			First Name			Health Card Number		
	Ad	ldress				Date of Birth			
						DD	ММ	YYYY	
Private Insurance	☐ Yes	□ No)		t of 3 rd Party				
Coverage?				Covera	ge				
					OVIDER				
Service	Provider		Service Provider ID #			Email Address			
	Address			Fax Number		Certified Orthopedic Professional			
							<u> </u>		
Certification /					Certification #				
Designation					(if applicable)				
Certified orthopedic			Client Diagnosis						
professional's signature Referring physician or									
nurse practitioner			Rx I		Rx Date				
		C	CLASS	II ORT	THOSES				
☐ Group A ☐ Group B ☐ Group C ☐ Group D (Refer to Policy)								to Policy)	
							☐ Left		
Make	Model			Size			☐ Right		
Applicable Criteria #'s Met (Refer to Policy)							Warranty	Information	
Detailed Description	n of Orthoses								
Justification for cri	teria not met and/	or Addi	tional I	nformati	on				
		0.7100.							

CLASS III ORTHOSES - CUSTOM MADE Applicable Criteria #'s Met (Refer to Policy) Left Right	CLIENT NAME:		HEALTH CARD #	:	
Detailed Description of Orthoses Warranty Information ORTHOSES REPAIRS, ADJUSTMENTS, MODIFICATIONS Repair Adjustment Modification Left Right Bilateral Age of Make (If applicable) (If applicable) Applicable Criteria #'s Met (Refer to Policy) Warranty Information Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information		CLASS III OI	RTHOSES - CU	STOM MADE	
Justification for criteria not met and/or Additional Information ORTHOSES REPAIRS, ADJUSTMENTS, MODIFICATIONS Repair Adjustment Modification Left Right Bilateral Age of Make (ff applicable) (ff applicable) Applicable Criteria #'s Met (Refer to Policy) Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information	Applicable Criteria #'s Me	et (Refer to Policy)			
ORTHOSES REPAIRS, ADJUSTMENTS, MODIFICATIONS Repair Adjustment Modification Left Right Bilateral Age of Make (if applicable) (if applicable) Applicable Criteria #'s Met (Refer to Policy) Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information	Detailed Description of O	Warranty Information			
Repair Adjustment Modification Left Right Bilateral Age of Item Make (if applicable) Applicable Criteria #'s Met (Refer to Policy) Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information	Justification for criteria n	ot met and/or Additio	nal Information		
Age of Item Make (if applicable) Model (if applicable) Applicable Criteria #'s Met (Refer to Policy) Warranty Information Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information	ORTH	OSES REPAIRS	, ADJUSTME	NTS, MODIFIC	CATIONS
Item	☐ Repair ☐ Adjustm	ent 🔲 Modification	□ Left	☐ Right	□ Bilateral
Description of Modification, Adjustment or Repair Justification for criteria not met and/or Additional Information					
Justification for criteria not met and/or Additional Information	Applicable Criteria #'s Mo	et (Refer to Policy)	,	,	Warranty Information
	Description of Modificati	on, Adjustment or Rep	oair		
ATTACHMENTS	Justification for criteria r	ot met and/or Additio	nal Information		
ALIAVIIWILITI		Δ٦	TACHMENT	rs	
☐ Physician's prescription ☐ Quote on Health Services invoice ☐ Statement of Benefits (private insurance only)	□ Physician's proscripti	of Ronofits (minute income			