



BIGSTONE HEALTH COMMISSION
Bigstone Health Benefits Medical Supplies and Equipment
Limb and Body Orthotics Prior Approval Form

BIGSTONE HEALTH COMMISSION
PROTECTED WHEN COMPLETED

Section 1: Client Information

Client Name:		Date of Birth:
Client Address:		
Telephone #:	PHN #:	Client ID #:

Section 2: Prescriber Information

Prescriber Name:	License #:
Telephone #:	Fax #:

Section 3: Client Health Information (MUST BE COMPLETED)

Diagnosis:		Reason for request:	
Explanation of benefit requirement and specific details of item to be provided:			
Is the benefit requested due to the result of an injury:		YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, please complete the following:
When did the injury occur?		Is the condition expected to last longer than 12-months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Where did the injury occur:		Please provide date of surgery or fracture if applicable:	
Home: <input type="checkbox"/>	Work: <input type="checkbox"/>	MVA: <input type="checkbox"/>	Other: <input type="checkbox"/>
Are any of these expenses covered under any other public or private health care plan:			Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 4: Equipment or Supplies requested

Description of benefit	Benefit Code	Qty	Cost Per Unit
Is the item custom-made?		Is the item custom-fitted?	

Section 5: Provider Information

Provider Name:		Provider Number:	
Telephone #:		Fax #:	
I hereby certify that the information is true and complete:		Date:	
Provider Signature:			
Is the provider a: <div style="display: flex; justify-content: space-between; margin-top: 10px;"><div><ul style="list-style-type: none">Certified Prosthetist Orthotist (CPO(c)) _____Certified Orthotist (CO(c)) _____Other: _____</div><div><ul style="list-style-type: none">Podiatrist (Doctor of Podiatric Medicine) (D.P.M.) _____BOC Pedorthist (BOCPD) _____</div></div>			
Bigstone Health Benefits			
Office Telephone: (780) 341-2777		Direct Line: (780) 341-2776	
Office Address: 16310 100 Avenue NW Edmonton, AB T5P 4X5		Office Fax: (780) 444-6521	

Submit with the following:

- Signed and dated prescription
- Manufacturer's invoice for devices exceeding maximum prices
- Additional information supporting the request for items, if available