NIHB PRIOR APPROVAL FORM
ORTHOTICS - CUSTOM FOOTWEAR - PROSTHETICS - PRESSURE GARMENTS

PA#: **DATE:**

Section 1: Patient Information

Patient's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:

Section 2: Prescriber Information

Prescriber's Name:	License / Billing #:
Telephone #:	Fax #:
Item Requested:	

Section 3: Client Health Information

Diagnosis (should be specific to the item being requested):
Explanation of benefit requirement based on clinical assessment by recognized provider and specific details of device to be provided (MUST BE COMPLETED): Will a follow up assessment be provided? Yes ☐ No ☐
Is the benefit requested due to the result of an injury? Yes ☐ No ☐ If **yes**, please complete the following:
Where did the injury occur? Home ☐ Work ☐ Other ☐ | When did the injury occur?
Are any of these expenses covered under any other public or private health care plan? Yes ☐ No ☐

Section 4:Equipment or Supplies Requested

Description of Device (**manufacturing technique, materials to be used, side of body, itemize replacement parts if it is a repair and details of warranty)**	Benefit Code	Qty	Cost	MFR Name (In-house or external?) MFR Item Code Class Type for orthoses/custom footwear

Section 5: Provider Information

Provider Name:	Provider #:
Provider Signature:	Date:
Telephone #:	Fax#:

Section 6: Client Signature

Client: I have received the above mentioned item(s). Signature:	Date: