BRITISH COLUMBIA | Ministry of Children and Family Development

MEDICAL BENEFITS REQUEST FOR ORTHOTICS

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Supply Act*. The collected information may be subject to disclosure as per the *Supply Act* and/or the *Freedom of Information and Protection of Privacy Act* (FOIPP Act). If you have any questions about the collection, use or disclosure of this information, please call Enquiry BC at 1 800 663-7867 and ask for the listing for Children and Youth with Special Needs Policy.

This request is for: ☐ Children in Care Medical Benefits Program* ☐ At Home Program Medical Benefits

*please provide a copy of this request to the child's guardianship worker

NAME OF CHILD	DATE OF BIRTH (YYYY/MM/DD)	PHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

SPECIFIC DIAGNOSIS (i.e. type of impairment, location and degree of involvement)

PART 1 To be completed by the orthotist, occupational therapist, physiotherapist, podiatrist or physician.

Identify the orthotic device required and what type of material the device is made from.
(please see the Glossary of Orthotic Devices, available at http://www.mcf.gov.bc.ca/at_home/pdf/glossary_ortho_devices.pdf)

☐ Cervical Collar	☐ Low-temperature ☐ High-temperature	☐ Wrist-Hand Resting Orthotic	☐ Low-temperature ☐ High-temperature	☐ Wrist Orthotic	☐ Low-temperature ☐ High-temperature	☐ Wrist-Hand Orthotic	☐ Low-temperature ☐ High-temperature
☐ Hand Orthotic	☐ Low-temperature ☐ High-temperature	☐ Ankle-Foot Orthotic*	☐ Low-temperature	☐ Foot Orthotic	☐ Low-temperature ☐ High-temperature	☐ Bilateral Twister Cables	☐ Orthopaedic Shoes***
☐ Other** _____ NAME OF DEVICE	☐ Low-temperature ☐ High-temperature						

* Requests for high-temperature ankle-foot orthotics should be forwarded to PharmaCare.
** Devices that do not appear in this list may not be available. For more information, please contact Medical Benefits at the telephone number at the end of the form.
*** Must be required to accommodate a medical condition, up to a limit of $200 per year

Please provide a clear justification for this device, which outlines its expected impact for the child (note the child's specific physical skills or limitations that the device is intended to address).

Is this item expected to be used for less than one year (e.g., post-surgical) and/or intermittently throughout the day? ☐ Yes ☐ No

NAME OF HEALTH CARE PROFESSIONAL	PROFESSION
SIGNATURE HEALTH CARE PROFESSIONAL	DATE SIGNED (YYYY/MM/DD)

PART 2 To be completed by the supplier.

PRICE QUOTED
$

Is this item a Pharmacare Benefit? ☐ Yes* ☐ No

*Items that are Pharmacare benefits should be forwarded to Pharmacare.

NAME OF SUPPLIER	PHONE NUMBER
	( )

ADDRESS	CITY/TOWN	POSTAL CODE

MAIL OR FAX COMPLETED FORM TO:

MEDICAL BENEFITS PROGRAM – AT HOME PROGRAM
MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
PO BOX 9763 STN PROV GOVT
VICTORIA BC V8W 9S5

FAX NUMBER: (250) 356-2159
PHONE NUMBER: (250) 387-9649 or 1-888-613-3232 (Toll Free)

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