PATIENT PROGRESS REPORT FOR CONTINUED PHYSIOTHERAPY SERVICES

To the Patient: Please refer to the Continued Physiotherapy Coverage letter issued with this report for additional information. This form must be completed in full by you and your physiotherapist for review by our Medical Consultant and/or Physiotherapist Consultant.

SECTION 1 - PATIENT INFORMATION			PROVIDER INFORMATION		
GREEN SHIELD NUMBER		DATE OF BIRTH (YY/MM/DD) ______/______/______	PROVIDER NUMBER		PROVIDER PHONE #
SURNAME	FIRST NAME		PROVIDER NAME		
ADDRESS			ADDRESS		
CITY	PROVINCE	POSTAL CODE	CITY	PROVINCE	POSTAL CODE
EMAIL			EMAIL		

SECTION 2 - MANDATORY DECLARATION

Do you have any other group Insurance coverage that may include these services as benefits? YES ☐ NO ☐

If Yes, please provide Insurance company's name ____

If other coverage is Green Shield Canada, indicate Green Shield Number: ____________________________________

If applicable, was patient referred to OHIP funded clinic YES ☐ NO ☐ If yes, number of treatments received ______________

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ Date of Accident (YY/MM/DD) __________________

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury (YY/MM/DD) ________________

SECTION 3 - DETAILS OF INJURY - MUST BE COMPLETED IN FULL BY THE PHYSIOTHERAPIST

Green Shield Canada will not approve coverage for additional physiotherapy services if they are part of a maintenance. We allow active therapy to rehabilitate the affected injury or body structure in an attempt to return to a pre-injury state.

WORKING DIAGNOSIS:		CURRENT AND PROPOSED TREATMENT DETAILS REQUIRED:
		FACTORS DELAYING RECOVERY:
DATE SYMPTOM(S) OCCURRED: ________ ________ ________ YEAR MONTH DAY	DATE OF SURGERY: ________ ________ ________ YEAR MONTH DAY	OCCUPATION: ARE YOU OFF WORK DUE TO THIS INJURY? ☐ YES ☐ NO
HOW DID THE INJURY OCCUR? PLEASE EXPLAIN:		

EXAMINATION FINDINGS

INITIAL SYMPTOMS AND RANGE OF MOTION (ROM, neurological testing, etc.)

CURRENT SYMPTOMS AND RANGE OF MOTION: (ROM, neurological testing, etc.)

CURRENT FUNCTIONAL LIMITATIONS:

RESULTS OF TREATMENT TO DATE (I.E. DEGREE OF IMPROVEMENT, EFFECTS ON ADL's, etc.)

OUTCOME WITH ADDITIONAL TREATMENTS

COMPLETE RECOVERY EXPECTED? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE APPROXIMATE DATE:

__________ YEAR __________ MONTH __________ DAY

RECOMMENED DURATION OF EXTENDED TREATMENT:

START DATE: __________ YEAR __________ MONTH _________ DAY END DATE: ___________ YEAR ___________ MONTH ___________ DAY

ESTIMATED FREQUENCY OF TREATMENT (E.g. # of days/week) ____________________________________

SECTION 4 - AUTHORIZATION

SIGNATURE OF PHYSIOTHERAPIST	DATE	PATIENT SIGNATURE

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

SECTION 5 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

NURSING / PHYSIO DEPT.
P.O. BOX 1699
WINDSOR, ON
N9A 7G6

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 **physio@greenshield.ca** **greenshield.ca**