

**PROSTHETIC AND ORTHOTIC SERVICES
Status Report**

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: (780) 427-5863
1-800-661-1993

Please print clearly or type.

		WCB Claim Number	Personal Health Number	Date of Accident (yyyy/mm/dd)
Worker's Surname		First Name	Initial	Date of Birth (yyyy/mm/dd)
Address		City/Town	Province Postal Code	Telephone Number ()
Referral Source Name				Referral Source Telephone Number ()
Provider Name				Provider Telephone Number ()
Claim Owner Contact Required <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify reason: _____				Date of Service (yyyy/mm/dd)
Reason for Service <input type="checkbox"/> New Prosthetic <input type="checkbox"/> Adjustment to Existing Prosthetic <input type="checkbox"/> Repair Existing Prosthetic <input type="checkbox"/> New Orthotic <input type="checkbox"/> Adjustment to Existing Orthotic <input type="checkbox"/> Repair Existing Orthotic <input type="checkbox"/> Other (Describe): _____ Date of Last New Prosthetic or Orthotic (yyyy/mm/dd): _____				
Assessment Findings _____ _____ _____				
Treatment Plan _____ _____ _____				
Authorization Required <input type="checkbox"/> New Prosthetic or Orthotic (Describe): _____ <input type="checkbox"/> Repair/Adjustment to Prosthetic > \$750.00 (Describe): _____ <input type="checkbox"/> Repair/Adjustment to Orthotic > \$200.00 (Describe): _____ <input type="checkbox"/> Other (Describe): _____				
Recommended Referral to Other Health Care Provider <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify type of provider: _____ If yes, please specify reason: _____				
Name and address to whom fee is payable (please print). WCB Billing Number: _____ Skill Code: ORPR Contract ID: 000011		Signature		
		Print Name		
		Telephone Number ()	Fax Number ()	
		Date (yyyy/mm/dd)	Provider File Number	

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.