ALBERTA INSTITUTE
FOR SPINE AND SPORT THERAPY

Third Party Coverage Information

Patient Name: _____

Insurance Company: _____

Policy Holder: _____

Group Number: _____

Plan Number: _____

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1. Does your policy cover custom orthotic insoles? ☐ Yes ☐ No
2. What is the annual limit with my plan?_____
3. Is there more than one orthotic permitted? ☐ Yes ☐ No
4. What is the renewal for this service with my plan? _____
5. What technique does my plan require to be the method of creating / manufacturing the orthotics?
   ☐ Foot Cast ☐ Computerized Foot Scan
6. Does my plan require a medical prescription? ☐ Yes ☐ No
   a. If Yes, does my medical prescription require a diagnosis? ☐ Yes ☐ No
7. Which type of prescriber is permitted with my plan?
   _____ Chiropractor
   _____ Medical Doctor
   _____ Pedorthotist
   _____ Podiatrist
   _____ Other
8. How often is a medical prescription required?
   _____ For each pair
   _____ January 1st
   _____ On Plan Renewal
   _____ Other: _____

Notes:

Please bring this form with you to your GAIT Scan

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