

## RENTAL OR PURCHASE OF A WHEELCHAIR

The **rental** of a wheelchair may be covered through The University of Western Ontario's Extended Health Plan. In order to assess this request, a written recommendation from the physician is required. Please ensure that the physician answers the following questions.

The **purchase** of a wheelchair could also be considered. In order for the cost to be considered, a written recommendation from the physician is required. **In addition to the physician's statement, please attach two cost estimates along with a complete description of the item.**

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### COMPLETE AS SHOWN ON YOUR CERTIFICATE

GROUP NUMBER: \_\_\_\_\_ CERTIFICATE NUMBER: \_\_\_\_\_

PLAN MEMBER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SIGNATURE OF PLAN MEMBER: \_\_\_\_\_

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### PHYSICIAN'S STATEMENT

PATIENT NAME & RELATIONSHIP TO PLAN MEMBER: \_\_\_\_\_

1. What is the diagnosis?
  
  
2. Explain the type of wheelchair? Manual or electric?
  
  
3. How long would the wheelchair be required?

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME AND ADDRESS OF PHYSICIAN (PLEASE PRINT)

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### PATIENT AUTHORIZATION

I hereby certify that the information provided in connection with this claim is true, accurate and complete and I hereby authorize any physician, hospital, provider, insurance company or pre-payment organization to give to Manulife Financial any additional information required in connection with this claim. A photocopy of this authorization shall be valid as the original.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

SUBMIT TO:  
MANULIFE FINANCIAL  
P.O. Box 400  
WATERLOO, ONTARIO N2J 4A9