CFPM

Canadian Federation of Podiatric Medicine

Please complete this form fully and accurately in order for the CFPM board to address/follow up with any specific insurance issue you have. Kindly note, we will not be able to proceed with an incomplete form. All contact information must be provided (*name, phone number and/or email address*) .

In order to assist you, CFPM would need to have a clear understanding of all history of events. If the patient has not yet followed up with their Human Resource Centre or Union Representative, please request that they do so before submitting this form.

DATE: _____

MEMBER: _____

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

POLICY NUMBER: _____

WORK PLACE	_____	INSURANCE	_____
ADDRESS	_____	ADDRESS	_____
	_____		_____
	_____		_____
	_____		_____
PHONE NUMBER	_____	PHONE NUMBER	_____
EMAIL ADDRESS	_____	EMAIL ADDRESS	_____
CONTACT NAME	_____	CONTACT NAME	_____
TITLE	_____	TITLE	_____
UNION REP NAME	_____	PHONE NUMBER	_____

Have you followed up with your Human Resources Department?

☐ Yes
☐ No
☐ Not applicable

If yes, please provide the name of the contact person and advise what the outcome was?

_____

_____

Have you followed up with your Union Rep?

☐ Yes
☐ No
☐ Not applicable

If yes, please provide advise what the outcome was?

_____

_____

History of Events (Please be brief, but specific, including dates. Please attach all correspondence)

_____

_____

_____

_____

_____

_____

What would you like the CFPM to do?

_____

_____

I hereby give the CFPM permission to act on my behalf regarding this issue. I understand that my name and other pertinent information may be used during inquiries and correspondence.

_____ _____

Member's Signature Patient's Signature

_____ _____

Date Date