



Prosthetic Estimate

Champ CHAMP Adult Adult Amputee

Centre name: _____ Client name: _____

Address: _____ Address: _____

Whom to contact for questions: _____ Tel.: _____

Tel.: _____ Email: _____

Email: _____

Work related to: <input type="checkbox"/> Conventional <input type="checkbox"/> Recreational (activity: _____) <input type="checkbox"/> Preparatory <input type="checkbox"/> Definitive
<input type="checkbox"/> New request <input type="checkbox"/> Revised request Reason: _____
Amputation level (e.g., BK or TT, AE or TH): <input type="checkbox"/> Left _____ <input type="checkbox"/> Right _____ <input type="checkbox"/> Bilateral _____
<input type="checkbox"/> Full fitting <input type="checkbox"/> Components <input type="checkbox"/> Adjustments/repairs <input type="checkbox"/> Supplies <input type="checkbox"/> Other (specify) _____

Please record the cost breakdown on page 2 or attach a list to this completed form.

- A copy of this form, signed by The War Amps, will be returned to you to indicate the amount of War Amps funding approved. Please provide us with a copy upon invoicing.
- Information collected may be processed by a third-party service provider.
- **Invoice note: Upon invoicing, providers are required to provide a copy of the client's signed Payment and Insurance form, stating the work has been completed to the client's satisfaction, as well as proof of payment from the other payors.**

For The War Amps Use Only	
Amount approved: \$ _____	
This approval will expire on: _____	
_____	_____
Authorizing signature	Date
Reference #: _____	
_____	_____

Authorization from centre (print/type name)

Date

