MEDAVIE BLUE CROSS™

MEMBER HEALTH CLAIMS SUBMISSION FORM

MEMBER INFORMATION

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY) _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ◯ Yes ◯ No If yes, signature of member is required for validation _____

OTHER COVERAGE

Do you or any of your dependents have coverage under any other plan?

◯ No If applicable, please provide the termination date (dd/mm/yyyy): _____

◯ Yes **If Yes, complete the following:** Name of other Insurer: _____

Member Name: _____ Effective Date: _____

Type of policy (✓): ◯ Individual ◯ Group

ID Number: _____ Policy Number: _____

Please indicate type of coverage(✓): ◯ Hospital ◯ Extended Health ◯ Dental ◯ Vision ◯ Drugs ◯ Travel ◯ HSA ◯ **All**

OTHER INFORMATION

Was treatment the result of an accident? ◯ **Yes** ◯ **No**

If yes, please complete the following and attach details of the accident.

1) Was treatment the result of an automobile accident? ◯ **Yes** ◯ **No**

2) Was treatment the result of an injury in the workplace? ◯ **Yes** ◯ **No**

If yes, has Worker's Compensation been advised? ◯ **Yes** ◯ **No**

CLAIM INFORMATION

	Patient's Name First Name	Last Name	**Relationship to Member** Self, Spouse, Child	**Date of Birth** day	month	year	**Type of Service** I.e.: Podiatry, diabetic supplies, eyeglasses, etc.	**Date of Service** day	month	year	**Amount Paid**
1											
2											
3											
4											
5											
6											
7											
										TOTAL CLAIM AMOUNT	

MEMBER STATEMENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-668-4511.

Signature _____ Date _____

(If under 18 years of age the signature of the member is required.)

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces
PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Quebec
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

Ontario
PO Box 2000 STN A
Etobicoke ON M9C 5P1
Inquiries: 1-800-667-4511

Other Provinces and Territories
PO Box 2318 STN Main
Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511

*** Please ensure all areas are complete. Incomplete information may delay processing. Please keep copies for your records.**
*** Please attach all original paid-in-full receipts. If receipts were submitted to another plan and the unpaid portion is now being claimed, please attach copies of all receipts, invoices and applicable referrals along with the original "explanation of benefits" statement from the other insurer.**
*** Prescription drug receipts must indicate name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.**
*** All receipts must indicate name of supplier/provider, item/service rendered and provider telephone number.**

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