MEDAVIE BLUE CROSS™

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Inquiries: 1-800-667-4511

CLINICAL MEASUREMENTS CLAIM FORM

CLIENT INFORMATION (This section to be completed by Subscriber)

Identification No.: _____ Policy No.: **91174**

Subscriber Last Name: _____ Subscriber First Name: _____

Address: _____

Telephone No.: _____ Date of Birth (DD/MM/YYYY): _____

PROVIDER INFORMATION (This section to be completed by Provider)

Provider Name: _____ Provider Type: _____

Address: _____

Telephone No.: _____

I hereby certify that I have provided the goods and/or services indicated below to the patient named below, and this is an accurate statement of the fees charged.

Signature of Provider: _____ Date: _____

CLAIM DETAILS

The following clinical measurements (height, weight, waist measurement, hip measurement, blood pressure, blood glucose, total cholesterol, triglycerides, high density lipoproteins, low density lipoproteins) are eligible for reimbursement.

Date of Service DD	MM	YY	Charged Amount

SUBSCRIBER STATEMENT (This section to be completed by Subscriber)

I hereby authorize the release of any information or records requested in respect to this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

Signature of Provider: _____ Date: _____

INTERNAL USE ONLY

Benefit Code O285

*** Please attach all original paid-in-full receipts.**

*** Please ensure all areas are complete. Incomplete information may delay processing.**

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