MEDAVIE BLUE CROSS™

MEMBER HEALTH CLAIMS SUBMISSION FORM

MEMBER INFORMATION

ID Number: ______________________ Policy Number: **91174** ______________ 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		Relationship to Member Self, Spouse, Child	Date of Birth			Type of Service I.e.: Podiatry, diabetic supplies, eyeglasses, etc.	Date of Service			Amount Paid
	First Name	Last Name		day	month	year		day	month	year	
1											
2											
3											
4											
5											
6											
7											
										TOTAL CLAIM AMOUNT	

MEMBER STATEMENT

I certify that I have not claimed and will not claim these expenses under any other insurance plan (unless indicated above) and that all information contained herein is correct.

I hereby authorize any health care providers to release to Medavie Blue Cross any information that relates to or supports claims submitted on my behalf and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Medavie Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature ______________________________ Date ______________
(If under 18 years of age the signature of the member is required.)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

ADDRESSES

Canada Atlantique
PO Box 220
644 Main St
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Québec :
PO Box 3300 STN B
Montreal QC
H3B 4Y5
Inquiries: 1-800-588-1212

Ontario :
PO Box 2000
185 The West Mall, Suite 1200
Etobicoke ON M9C 5P1
Inquiries: 1-800-355-9133

* **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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