MANITOBA BLUE CROSS

EXTENDED HEALTH BENEFITS CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM. FAMILY MEMBERS MAY SUBMIT A COMBINED CLAIM FOR PRESCRIPTION DRUGS.

- COMPLETE THE CLAIM BY ENTERING THE APPROPRIATE AMOUNT IN EACH OF THE SPACES BELOW.
- ENCLOSE **ITEMIZED RECEIPTS** FOR EACH SERVICE.
- EFFECTIVE JANUARY 1, 2000, RECEIPTS WILL NO LONGER BE RETURNED.
- FOR BENEFITS ASSIGNED TO PROVIDERS, ENCLOSE **ITEMIZED** STATEMENTS FOR EACH SERVICE.
- CLAIMS MUST BE SUBMITTED WITHIN 2 YEARS OF DATE OF SERVICE, UNLESS OTHERWISE STATED IN POLICY PROVISIONS.

GROUP NUMBER	BLUE CROSS CONTRACT NUMBER	SURNAME	CLAIMANT FIRST NAME	BIRTHDATE DAY / MONTH / YEAR

STREET, P.O. BOX NO.	CITY TOWN VILLAGE	POSTAL CODE	HAS YOUR ADDRESS CHANGED IN THE PAST YEAR? ☐ YES ☐ NO

WAS TREATMENT THE RESULT OF:
A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO
AN INJURY AT THE WORKPLACE? ☐ YES ☐ NO

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

POLICYHOLDER OF OTHER PLAN _____

BIRTHDATE _____ / _____ / _____
DAY MONTH YEAR

EMPLOYER _____

EMPLOYER'S INSURANCE COMPANY _____

POLICY OR CONTRACT NUMBER _____

IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

1. AGE OF THE CHILD _____
2. IS HE/SHE MARRIED? ☐ YES ☐ NO
3. IS HE/SHE EMPLOYED FULL-TIME? ☐ YES ☐ NO
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? ☐ YES ☐ NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ☐ YES ☐ NO

BENEFITS CLAIMED		TOTAL AMOUNT
DRUGS (ENCLOSE OFFICIAL PHARMACARE RECEIPTS OR A PHOTOCOPY)		
OTHERS (PLEASE SPECIFY)		

BENEFITS CLAIMED		TOTAL AMOUNT

TO HELP REDUCE ADMINISTRATIVE EXPENSES, RECEIPTS FOR SMALL CLAIMS SHOULD BE ACCUMULATED UNTIL THEY TOTAL AT LEAST $25.00.

IF LESS THAN $25.00 SUBMIT AT THE END OF THE CALENDAR YEAR.

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? ☐ YES ☐ NO

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:

NAME _____

ADDRESS _____

_____ POSTAL CODE _____

I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT.

SUBSCRIBER'S SIGNATURE _____

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE CONTRACT.

SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN) _____
(PLEASE SIGN HERE)

DATE _____

OFFICE USE ONLY

RECEIVED	ASSESSED
DATE:	
CHECKED	AUDIT
DATE: INIT.	DATE: INIT.

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7 PHONE 775-0151 OR TOLL FREE WITHIN MANITOBA 1-800-USE-BLUE (1-800-873-2583)

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba 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 develop and recommend suitable products and services to me, and to manage the Company'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 include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group 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, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or toll free at 1-800-873-2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

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