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		Relationship to Member	Date of Birth			Type of Service	Date of Service			Amount Paid
	First Name	Last Name	Self, Spouse, Child	day	month	year	I.e.: Podiatry, diabetic supplies, eyeglasses, etc.	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.

MEDAVIE BLUE CROSS ADDRESSES

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Halifax NS B3J 3C6
Site: 230 Brownlow Ave, Dartmouth
Inquiries: 1-800-667-4511

Newfoundland and Labrador
Viking Building
136 Crosbie Road, Suite 204
St. John's NL A1B 3K3
Inquiries: 1-800-667-4511

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