MEDAVIE BLUE CROSS™

VISION CLAIM FORM

PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS

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 other coverage under any other plan?

❑ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

❑ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ❑ **Individual** ❑ **Group** Effective Date: _____ Policy Number: _____

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

MEMBER STATEMENT

I hereby authorize any and all vision 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 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 **X** _____ 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.

VISION CLAIM INFORMATION - To be completed by the Provider

Provider Name: _____ Provider No.: _____ Telephone: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

Is this a new patient? ❑ Yes ❑ No Are lenses required due to a medical condition/disease? ❑ Yes ❑ No

If Yes, state condition/disease: _____

Benefit Description		Date of Service DD/MM/YYYY *(Date Goods Paid-in-full)*	Charge *(Must be broken down by benefit description)*
Eye Examination			
Frame			
Lens	Right		
	Left		
Tinting			
UV Coating			
Anti-reflection Coating			
Plano Sunglasses			
Contact Lens	Right		
	Left		
Other *			
		TOTAL	

* Description of Other: _____

Details of this prescription

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					
ADD R					
ADD L					

Bifocal Type ❑ Round ❑ ST

If changed, details of last prescription

(This information is not required if this is a new patient)

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					
ADD R					
ADD L					

Bifocal Type ❑ Round ❑ ST

Type of Right Lens:

❑ Single ❑ Bifocal
❑ Multifocal ❑ Progressive
❑ Spherical ❑ Compound
❑ Hi Index ❑ Polycarbonate
❑ Aspheric ❑ Slaboff

Type of Left Lens:

❑ Single ❑ Bifocal
❑ Multifocal ❑ Progressive
❑ Spherical ❑ Compound
❑ Hi Index ❑ Polycarbonate
❑ Aspheric ❑ Slaboff

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: **X** _____ Date: _____

MEDAVIE BLUE CROSS ADDRESSES

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