

## **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 BLUE CROSS CONTRACT NO. SURNAME	ONTRACT NO. SURNAME			CLAIMANT FIRST NAME				
STREET, P.O. BOX NO	CITY		TOWN VILLA	GE POS	TAL CODE	HAS YO	MONTH   YEAR 	
							ES 🔲 NO	
WAS TREATMENT THE RESULT OF		IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:						
☐ YES ☐ NO AN INJURY AT THE WORK PLACE? ☐ YES ☐ NO A MOTOR VEHICLE ACCIDENT?		1. AGE OF CHILD						
ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?		2. IS HE/SHE UNMARRIED				YES	☐ NO	
IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM 1ST INSURER.			3. IS HE/SHE EMPLOYED FULL-TIME  YES NO					
☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING			IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL  COLLEGE, OR UNIVERSITY  YES IN NO					
POLICY HOLDER OF OTHER PLAN								
BIRTH DATE/////			IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT					
EMPLOYER								
EMPLOYER'S INSURANCE COMPANY								
POLICY OR CONTRACT NUMBER								
	TOTAL						TOTAL	
BENEFITS CLAIMED	AMOUNT		BEN	IEFITS CLAIN	MED		AMOUNT	
DRUGS (ENCLOSE OFFICIAL PHARMACARE RECEIPTS OR A PHOTOCOPY)								
OTHERS (PLEASE SPECIFY)								
		IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?						
		☐ YES ☐ NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:						
		NAME						
TO LIEUR REPUICE ADMINISTRATIVE EVENINGS RECEIPTS FOR CALL			ADDRESS					
TO HELP REDUCE ADMINISTRATIVE EXPENSES, RECEIPTS FOR SMALL CLAIMS SHOULD BE ACCUMULATED UNTIL THEY TOTAL AT LEAST \$25.00		POSTAL CODE						
IF LESS THAN \$25.00 SUBMIT AT THE END OF THE CALENDAR YEAR.			I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RE-					
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.		SPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT.  SUBSCRIBER'S SIGNATURE						
		BLUE CROSS OFFICE USE ONLY						
		RECEIVED ASSESSED						
SIGNATURE OF PATIENT								
(OR PARENT/GUARDIAN) (PLEASE SIGN HERE)		DATE:	CHECKED	Di	ATE:	AUDIT		
DATE		DATE:	INIT.	Di	ATE:	INIT.		

## **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 at 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.