

MEMBER INFORMATION	
ID Number: _____	Policy Number: _____ Provincial Health Plan No. (applies only to BC and SK residents): _____
Last Name: _____	First Name: _____ Date of Birth (DD/MM/YYYY): _____
Address: _____	City: _____ Province: _____ Postal Code: _____
Home Telephone No.: ( _____ )	Work Telephone No.: ( _____ )
Has your mailing address changed since your last claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, complete the following:</b>
Name of other Insurer: _____
Member Name: _____
ID Number: _____ Policy Number: _____
Effective Date: _____ Termination Date: _____
<b>Please indicate type of coverage (✓) :</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Extended Health <input type="checkbox"/> Dental <input type="checkbox"/> Eye Wear <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> All

DEPENDENT INFORMATION
If the claimant is an over age dependent (as defined in your Plan), please complete the following:
1. Age of Child _____
2. Is he/she unmarried? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is he/she employed full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is he/she attending school, college or university full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is he/she physically or mentally handicapped and dependent on you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER INFORMATION
Was treatment the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, please complete the following and attach details of the accident:</b>
- Was treatment the result of an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
- Was treatment the result of an injury in the workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, has Worker's Compensation been advised? <input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIM INFORMATION												
	Claimant's Name		Relationship to Member <small>Self, Spouse, Child</small>	Date of Birth			Type of Service <small>E.g. Physiotherapy; diabetic supplies; eye glasses; etc.</small>	Drug Identification Number (DIN) <small>(if applicable)</small>	Date of Service			Amount Paid
	First Name	Last Name		day	month	year			day	month	year	
Eg	ED	SMITH	Self	01	05	1980	Drugs	01234567	01	10	2007	\$35.00
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
<b>TOTAL CLAIM AMOUNT</b>												

CLAIMANT STATEMENT
<p>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.</p> <p>I hereby authorize the release of any information or records requested in respect to this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.</p> <p>I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by my Blue Cross plan may be collected, used, or disclosed to administer and manage the terms of my plan or the group plan of which I am an eligible member or dependent, to recommend suitable products and services to me, and to manage my Blue Cross plan's business. For the purposes listed above, limited personal information may be collected from and/or released to a third party. This third party may include another Blue Cross organization, a licensed physician, health care professional or institution, life and health insurer, government and regulatory authorities, the member of any plan under which I am a dependent or another third party.</p> <p>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 my Blue Cross plan 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.</p> <p>I authorize my Blue Cross plan to collect, use and disclose my personal information as described above.</p> <p>Signature _____ Date _____</p> <p><small>(If under 18 years of age, the signature of the member is required)</small></p> <p><small>This consent complies with federal and provincial privacy laws. For additional information regarding your Blue Cross plan's privacy policies, call 1-888-873-9200.</small></p> <p><small>*applicable in Atlantic Canada</small></p>

**Please see back page for instructions on how to complete this form and our mailing addresses.**

## IMPORTANT CLAIMING INFORMATION

Please provide all information requested. Incomplete claims may cause delays in processing.

- 1 Complete all areas on the front of this claim form.
- 2 Please refer to your Blue Cross card for your Policy and ID numbers.
- 3 **Keep a copy of your receipts and documents for your records.**
- 4 All claims must be submitted with itemized statements and original paid-in-full receipts, including the following:
  - Claimant's First and Last Name
  - Description of item purchased or service rendered
  - Date of each purchase or service
  - Amount charged for each purchase or service
  - Address and telephone number of supplier / provider
- 5 Claims must be received in our office before the claiming deadline.
- 6 An Explanation of Benefits statement indicating how this claim was assessed will be sent to the member. If applicable, it will be accompanied by a cheque. The statement can be used for income tax purposes or to claim through another insurance plan. Please retain the Explanation of Benefits as no other statements will be issued.

**Photocopies are not acceptable, unless the following situation applies.**

### Other Coverage:

- 1 If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.
- 2 If both you and your spouse have health benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. (Example: if your birthday is May 1 and your spouse is June 5, your children will claim under your plan first).
- 3 If you have submitted your original receipt to your other insurance company, please provide the following:
  - A photocopy of all invoices and paid-in-full receipts.
  - Original statement from the other insurance company showing their payment / denial of the claim.

## ADDRESSES\*

**Alberta**  
10009 - 108th St NW  
Edmonton AB T5J 3C5

**British Columbia**  
PO Box 7000  
Vancouver BC V6B 4E1

**Manitoba**  
PO Box 1046  
Winnipeg MB R3C 2X7

**New Brunswick and  
Prince Edward Island**  
PO Box 220  
644 Main St  
Moncton NB E1C 8L3

**Newfoundland and Labrador**  
66 Kenmount RD Suite 102  
Kenmount Business Centre  
St. John's NL A1B 3V7

**Nova Scotia**  
PO Box 2200  
Halifax NS B3J 3C6

**Ontario**  
PO Box 2000  
185 The West Mall Suite 1200  
Etobicoke ON M9C 5P1

**Quebec**  
550 Sherbrooke West  
PO Box 3300, Postal Station B  
Montreal QC H3B 4Y5

**Saskatchewan**  
PO Box 4030  
516 2nd Avenue N  
Saskatoon SK S7K 3T2

**For all inquiries please call,  
1-888-873-9200**