MEDAVIE BLUE CROSS™

# PROVIDER CLAIM 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 dependents have coverage under any other plan? ☐ Yes ☐ No

☐ **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 ☐ Extended Health ☐ Dental ☐ Vision ☐ HSA ☐ Drugs ☐ Travel ☐ **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

## 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 and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life) any information that relates 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, 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 Medavie Blue Cross and/or Blue Cross Life'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 Medavie Blue Cross and/or Blue Cross Life 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 and/or Blue Cross Life 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 and/or Blue Cross Life 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 and/or Blue Cross Life, visit www.medavie.bluecross.ca or call 1-800-667-4511.

## DETAILS OF CLAIM - To be completed by provider

Provider Name _____ Provider No. _____ Telephone _____

Address _____ City _____ Prov. _____ Postal Code _____

Patient Name: _____ Diagnosis/description of presenting problem or complaint: _____

☐ Written Referral by Physician Date of RX: _____ Name of Physician: _____

☐ Patient does not have a physician ☐ Self-referred

| Date of Service | | | Select Provider Type (X) | | | | Description of Services/Products | Location of Service (home, hospital, clinic, other) | Benefit Code* (If Applicable) | Charges |
|---|---|---|---|---|---|---|---|---|---|---|
| DD | MM | YYYY | Chiropractic | Physiotherapy | Massage Therapy | Other (specify) | | | | |
| | | | ☐ | ☐ | ☐ | | | | | $ |
| | | | ☐ | ☐ | ☐ | | | | | |
| | | | ☐ | ☐ | ☐ | | | | | |
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| | | | ☐ | ☐ | ☐ | | | | | |
| | | | ☐ | ☐ | ☐ | | | | | |
| | | | | | | | | | **Total Charges:** | $ |

*Please consult the Medavie Blue Cross Benefit Grid

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 pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.

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

## MEDAVIE BLUE CROSS ADDRESSES

**Atlantic Provinces**
644 Main St PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

**Quebec**
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

**Ontario**
PO Box 2000 STN A
Etobicoke ON M9 C5P1
Inquiries: 1-800-667-4511

**Other Provinces and Territories**
PO Box 2318 STN Main
Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511

* **Please ensure all areas are complete.** *** Please attach all original paid-in-full receipts.**