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 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 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 **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.

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)				
										$

*Please consult the Medavie Blue Cross Benefit Grid **Total Charges:** $

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

New Brunswick and Prince Edward Island
644 Main St PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Nova Scotia
230 Brownlow Ave, Dartmouth
PO Box 2200 Halifax NS B3J 3C6
Inquiries: 1-800-667-4511

Newfoundland and Labrador
66 Kenmount Road, Suite 102
Kenmount Business Centre
St. John's NL A1B 3V7
Inquiries: 1-800-667-4511

Ontario
185 The West Mall Suite 1200
Etobicoke ON M9C 5P1
Inquiries: 1-800-355-9133

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