NATIONAL CLAIM FORM
HEALTH • DENTAL
HEALTH SPENDING ACCOUNT

Please see back page of this form for addresses.

MEMBER INFORMATION

Identification Number: ____________________ Policy Number: ____________________

Last Name: ____________________ First Name: ____________________

Address: ____________________

City: ____________________ Province: ____________________ Postal Code: ____________________

Daytime Telephone Number: ____________________ Employer: ____________________

COORDINATION OF BENEFITS

Are any benefits or services being claimed available to you or your dependents from any other group insurance, WCB or Government Plan? ❑ Yes ❑ No

If Yes, complete the following:

Name of other Insurer: ____________________ Cardholder Name: ____________________

Identification Number: ____________________ Policy Number: ____________________

Effective Date: ____________________ Term Date: ____________________

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

Name of Person(s) insured under other policy	Spouse / Dependent	Date of Birth		
		Day	Month	Year

If student, provide Name of Institution: ____________________

School Term: ____________________

OTHER INFORMATION

Is this claim due to an accident? ❑ Yes ❑ No **(If No, move to "Claim Information")**

If Yes, please complete the following:

- Did the accident happen as a result of an automobile accident? ❑ Yes ❑ No
- Did the accident happen while you were at work? ❑ Yes ❑ No
  If Yes, has Worker's Compensation been advised? ❑ Yes ❑ No File No.: ____________________

If Yes to any of the above, please complete the following:

- Date of the accident: ____________________ Location of the accident: ____________________
  Brief description of the accident: ____________________

- Has a claim been made to recover damages from the responsible person(s)? ❑ Yes ❑ No
  If Yes, please indicate claim number: ____________________
  If No, do you intend to make a claim against the responsible person(s)? ❑ Yes ❑ No

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HEALTH SPENDING ACCOUNT CLAIM SUBMISSION

Please complete the following if you want to claim against your Health Spending Account.

Canada Revenue Agency (CRA) requires you to claim all medical expenses through your provincial and group insurance plans before payment can be made from a Health Spending Account.

I confirm that benefits under this plan, any government program or alternate group plan (i.e. spouse's coverage) have been accessed.

❑ Please reimburse the expense(s) for which receipts from the provider of service and/or cheque stubs from other insurance companies are attached.

❑ Please reimburse any unpaid portion(s) of this ❑ Extended Health Claim or the attached ❑ Dental Claim

I, the undersigned, accept full responsibility that all expenses incurred and submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Federal Income Tax Act. If claiming expenses for an uninsured dependent under your Health/Dental contract: I, the undersigned, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

I certify that I have not claimed and will not claim these expenses under any other insurance plan, and that all information contained herein is correct.

Member Signature: ______________________ **Date:** ______________

CLAIM INFORMATION

Patient's Name *(Indicate Last Name if different from member)*		Relationship to Member **S** = Spouse **C** = Child **ST** = Student	Date of Birth			Date of Service / Purchase			Type of Expense E.g. Physiotherapy; diabetic supplies; chiropractor; eye wear; prescription drug; etc.	Amount	Apply Unpaid Balance to HSA Plan (Check for each Expense)	
First Name	Last Name		day	month	year	day	month	year			Yes	No
									Total			

MEMBER STATEMENT

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.

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.

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.

I authorize my Blue Cross plan to collect, use and disclose my personal information as described above.

Signature______________________ 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 your Blue Cross plan's privacy policies, call 1-888-873-9200.
*applicable in Atlantic Canada

ADDRESSES*

Atlantic Canada
PO Box 220
644 Main St
Moncton NB
E1C 8L3

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

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

Manitoba
PO Box 1046
Winnipeg MB
R3C 2X7

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

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

British Columbia
PO Box 7000
Vancouver BC
V6B 4E1

INQUIRIES: 1-888-873-9200

*** Please ensure all areas are complete.**
*** Please attach all original paid-in-full receipts; if receipts were submitted under another plan and the unpaid portion is now being claimed, please attach copies of your receipts along with the original "Explanation of Benefits" statement from the other insurer.**
*** Prescription drug receipts must indicate: name; strength and quantity of drug; drug identification number (DIN); prescription number (RX); patient's name.**
** Each plan is an independent licensee of the Canadian Association of Blue Cross Plans.*