MEDAVIE BLUE CROSS™

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59

new Find out what's new at Medavie Blue Cross

Today I'd like to:

- Buy Insurance
- Find a Quick Pay location
- Find a form
- Submit a claim
- Find out information about my travel coverage

Quick Links:

- Pharmacy Value Finder
- Info for Providers
- Blue Advantage
- Sign in to your account

Tweets Follow

Medavie Blue Cross @MedavieBC 8h

Our Blue Nose Marathon contest ends today. Not registered? Like & comment about health/wellness to win! fb.me/MedavieBlueCro... #BlueNose2013

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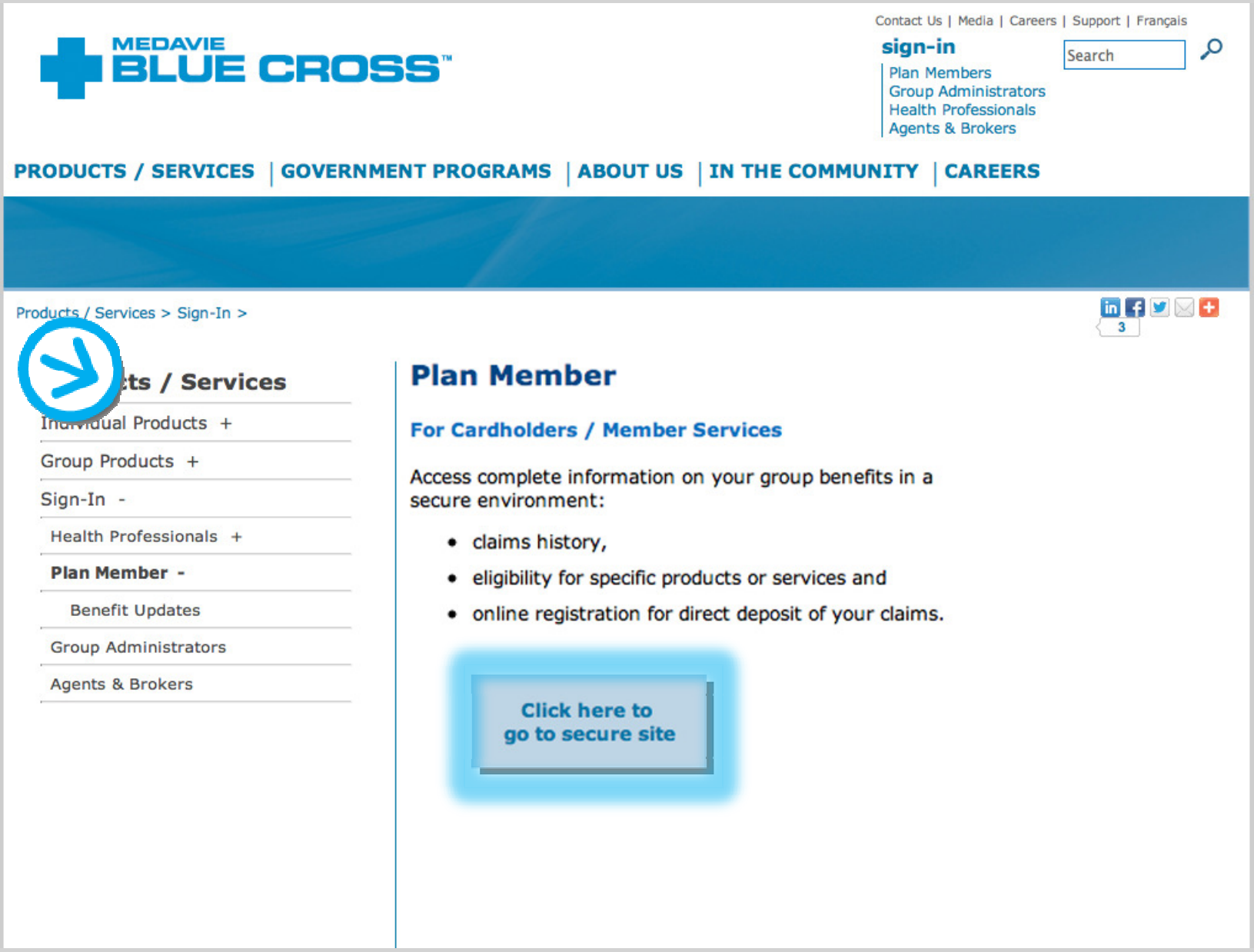
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For Cardholders / Member Services
Access complete information on your group benefits in a secure environment:
claims history,
eligibility for specific products or services and
online registration for direct deposit of your claims.
Click here to go to secure site

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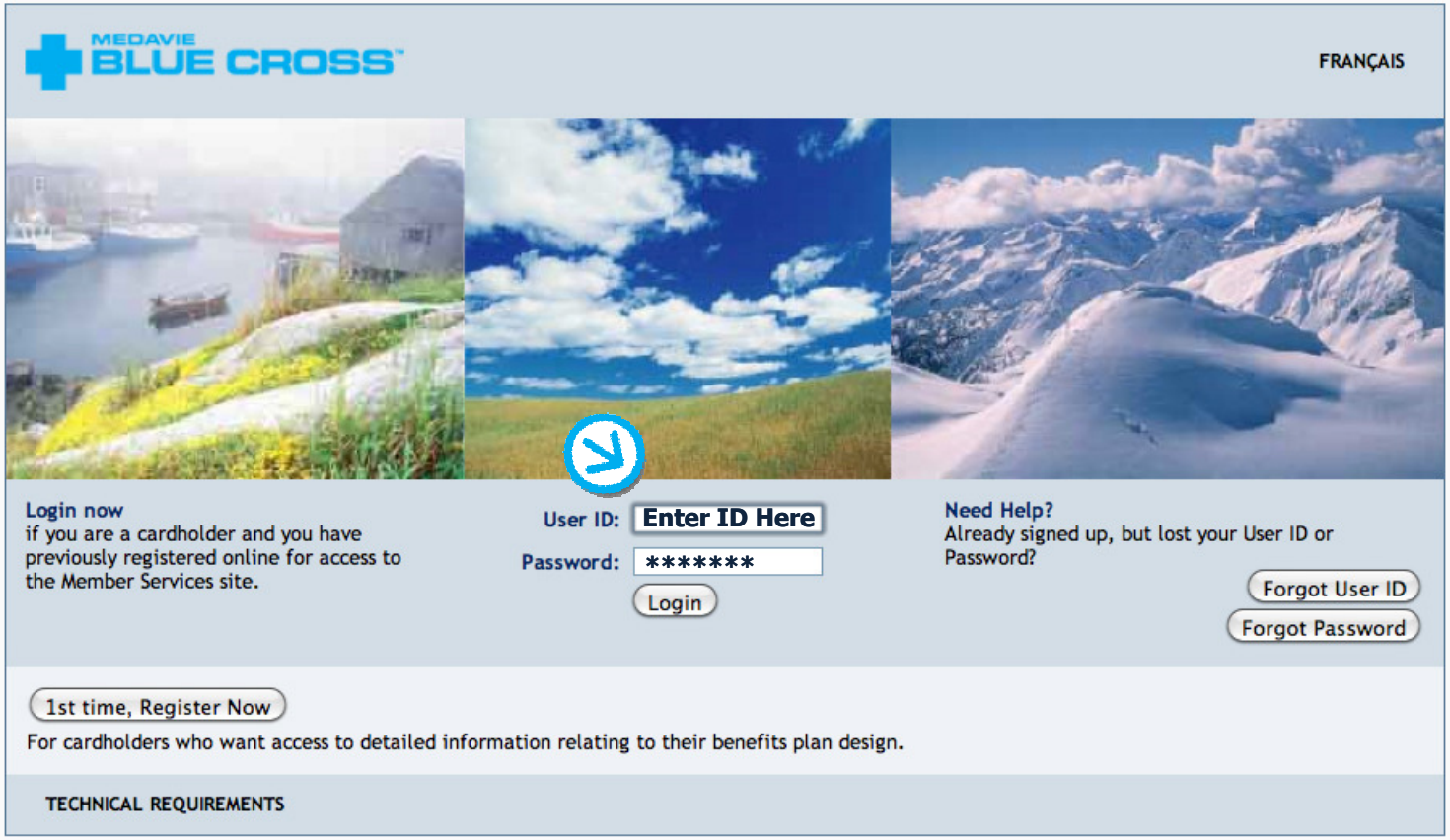
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Login now
if you are a cardholder and you have previously registered online for access to the Member Services site.
User ID:
Enter ID Here
Password:
****
Login
Need Help?
Already signed up, but lost your User ID or Password?
Forgot User ID
Forgot Password
1st time, Register Now
For cardholders who want access to detailed information relating to their benefits plan design.
TECHNICAL REQUIREMENTS

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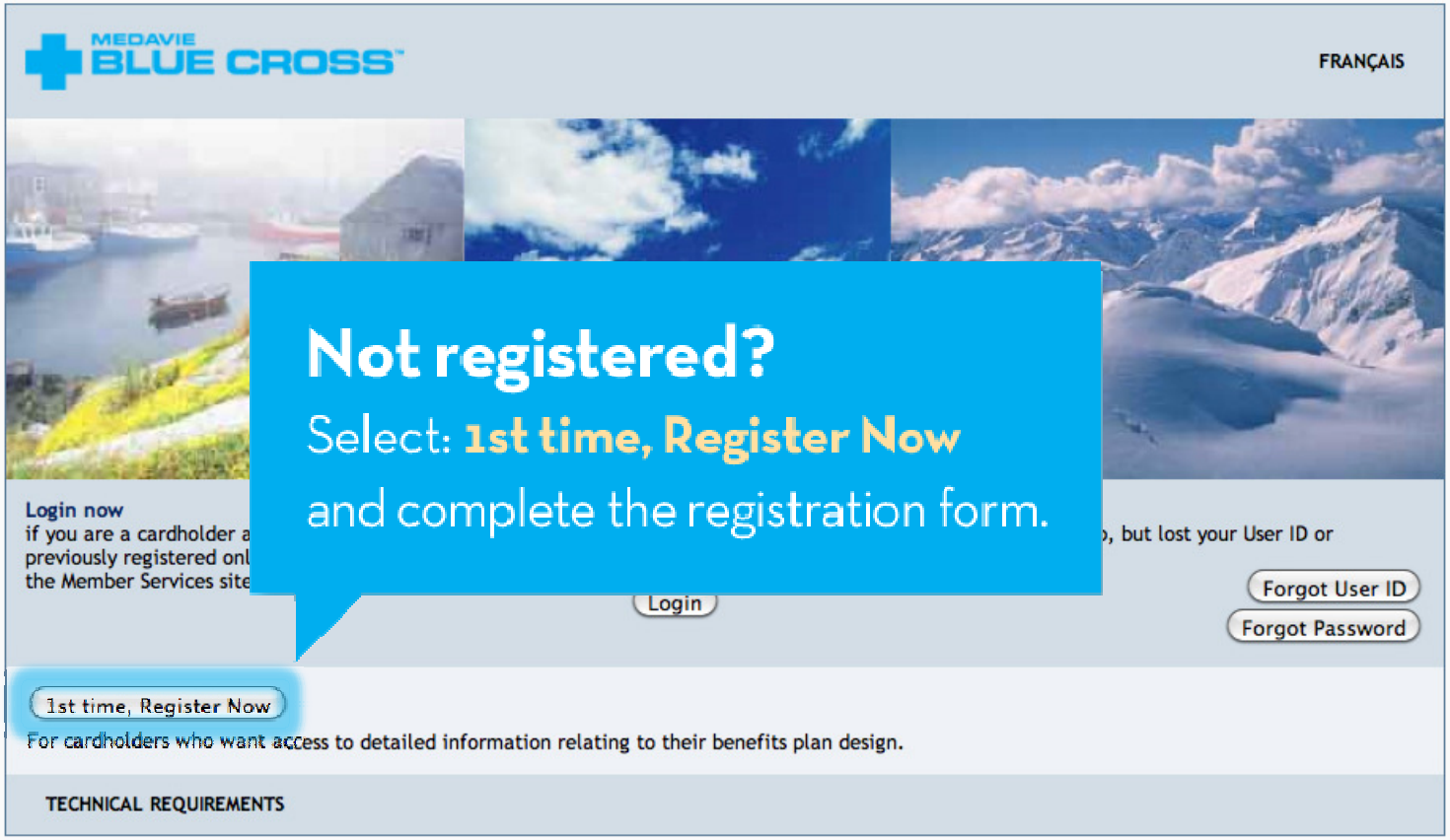
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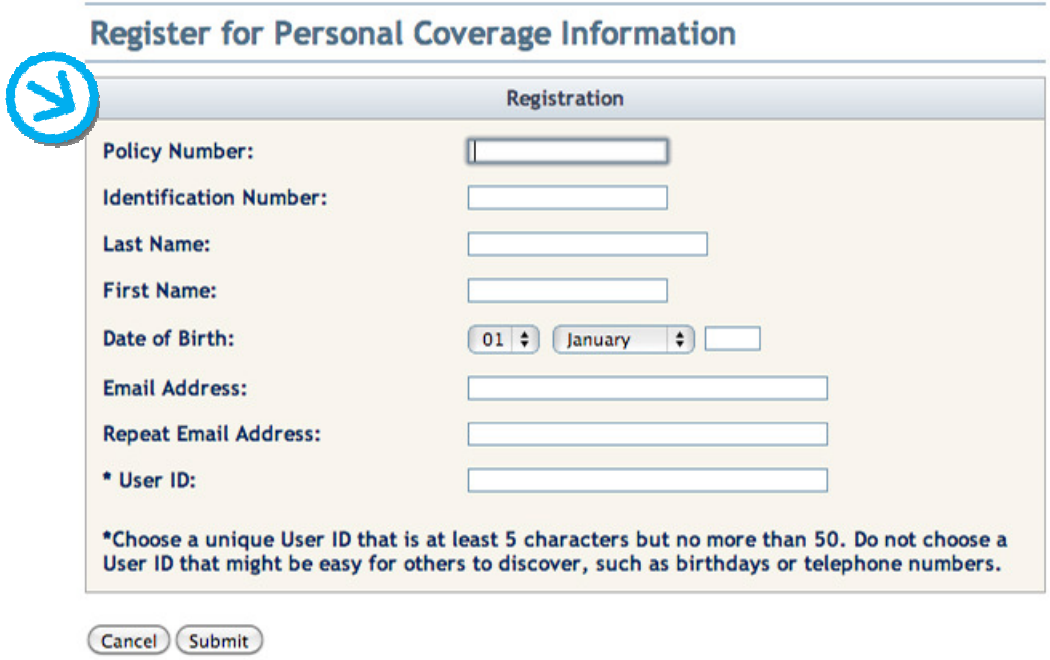
Not registered?
Select: 1st time, Register Now
and complete the registration form.
Login now
if you are a cardholder a
previously registered onl
the Member Services site
, but lost your User ID or
Login
Forgot User ID
Forgot Password
1st time, Register Now
For cardholders who want access to detailed information relating to their benefits plan design.
TECHNICAL REQUIREMENTS


Register for Personal Coverage Information
Registration
Policy Number:
Identification Number:
Last Name:
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01
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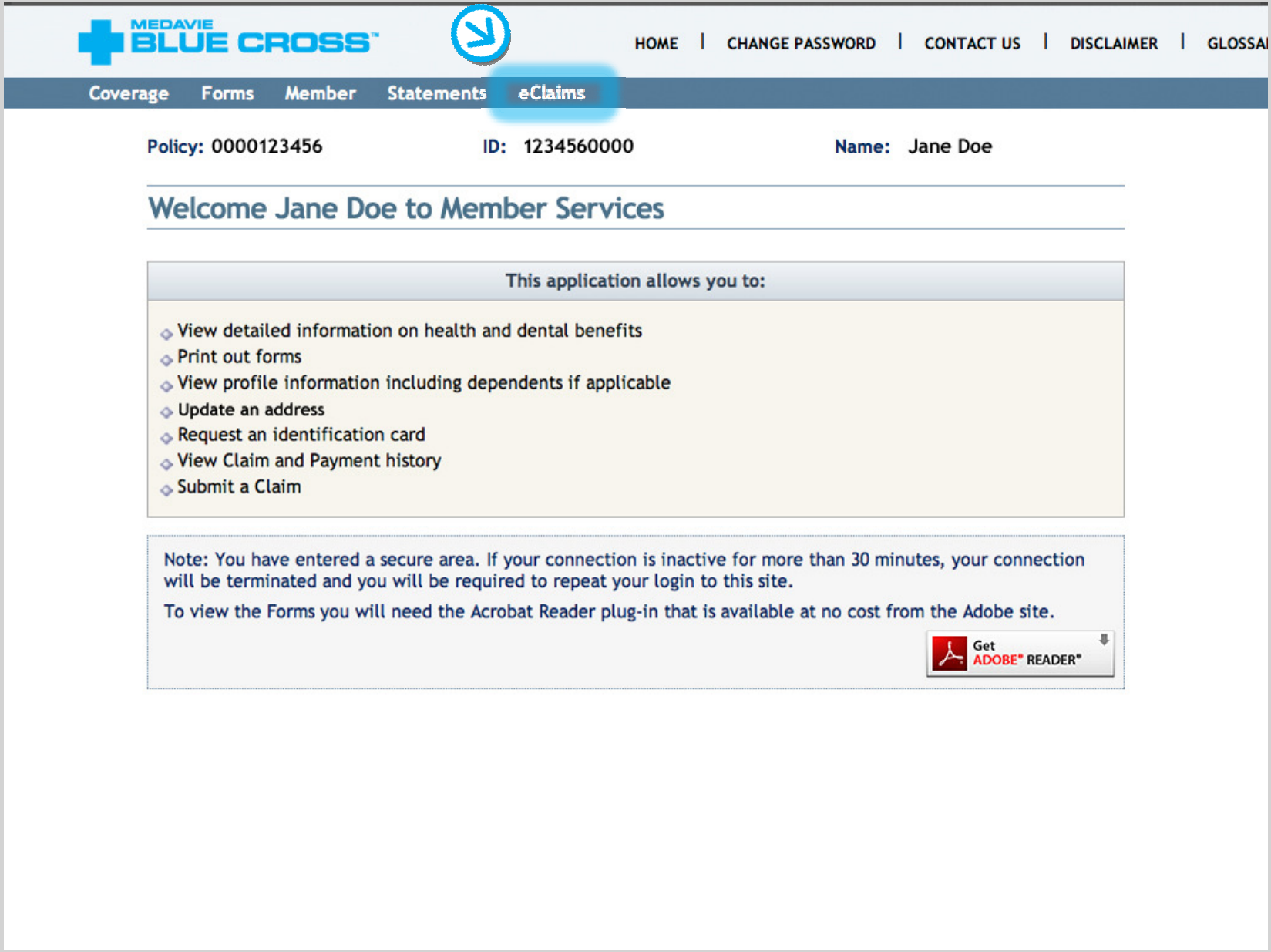
Email Address:
Repeat Email Address:
* User ID:
*Choose a unique User ID that is at least 5 characters but no more than 50. Do not choose a User ID that might be easy for others to discover, such as birthdays or telephone numbers.
Cancel
Submit


MEDAVIE BLUE CROSS
HOME | CHANGE PASSWORD | CONTACT US | DISCLAIMER | GLOSSA
Coverage Forms Member Statements eClaims
Policy: 0000123456 ID: 1234560000 Name: Jane Doe
Welcome Jane Doe to Member Services
This application allows you to:
View detailed information on health and dental benefits
Print out forms
View profile information including dependents if applicable
Update an address
Request an identification card
View Claim and Payment history
Submit a Claim
Note: You have entered a secure area. If your connection is inactive for more than 30 minutes, your connection will be terminated and you will be required to repeat your login to this site.
To view the Forms you will need the Acrobat Reader plug-in that is available at no cost from the Adobe site.
Get ADOBE® READER®

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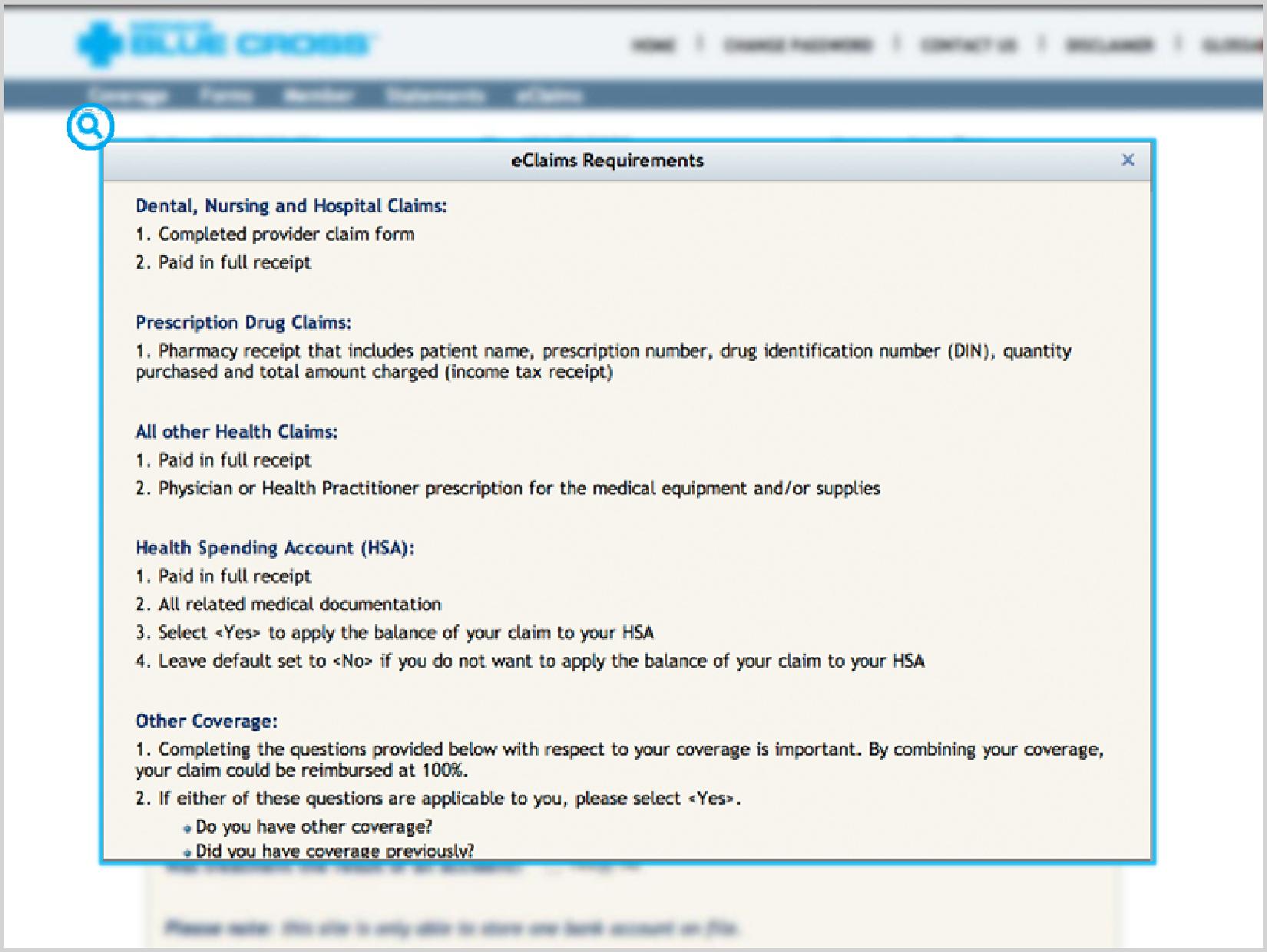

eClaims Requirements
Dental, Nursing and Hospital Claims:
1. Completed provider claim form
2. Paid in full receipt
Prescription Drug Claims:
1. Pharmacy receipt that includes patient name, prescription number, drug identification number (DIN), quantity purchased and total amount charged (income tax receipt)
All other Health Claims:
1. Paid in full receipt
2. Physician or Health Practitioner prescription for the medical equipment and/or supplies
Health Spending Account (HSA):
1. Paid in full receipt
2. All related medical documentation
3. Select <Yes> to apply the balance of your claim to your HSA
4. Leave default set to <No> if you do not want to apply the balance of your claim to your HSA
Other Coverage:
1. Completing the questions provided below with respect to your coverage is important. By combining your coverage, your claim could be reimbursed at 100%.
2. If either of these questions are applicable to you, please select <Yes>.
Do you have other coverage?
Did you have coverage previously?

« Prev Next »

Submit a Claim

Name: Jane Doe

Email: janedoe@email.com

Telephone: 555 555 - 0255

Language: (•) English ( ) French

Apply unpaid balance to HSA? ( ) Yes (•) No

Do you have other coverage? ( ) Yes (•) No

Did you have coverage previously? ( ) Yes (•) No

Was treatment the result of an accident? ( ) Yes (•) No

Please note: *this site is only able to store one bank account on*

Mandatory fields must be completed.

Branch # 12345 **Bank #** 670 **Account #** 1234567

Click on cheque to enlarge image

Attach File (s) [ ] Browse...

Please read and accept the Terms and Conditions

By submitting a claim using this online submission service, I declare the following:

I acknowledge that my claim is subject to my Health and Dental contract and that the expenses listed in my claim may not be covered by or may exceed my plan benefits. I am responsible to my healthcare provider for the cost of the entire treatment or service provided to me.

My claim is a true, correct and complete statement of expenses charged to me by my healthcare provider(s) for services rendered. I have not claimed and will not claim these expenses under another insurance plan or program, unless otherwise indicated in my claim.

I acknowledge that I must retain all original documents supporting the statement of expenses for a minimum of

I agree to the Terms and Conditions [ ] FAQ

« Prev Next »

Submit a Claim

Name: Jane Doe
Email: janedoe@email.com
Telephone: 555 555 - 0255
Language: (•) English ( ) French

Apply unpaid balance to HSA? (•) Yes ( ) No
Do you have other coverage? (•) Yes ( ) No
Has your other coverage changed? (•) Yes ( ) No
Type of policy: ( ) Individual (•) Group

Name of other Insurer: ABC Insurance
Member Name: Jane Doe
Effective Date (dd/mm/yyyy): 20/12/2012

If member answers **YES** additional fields will display and must be completed.

Please Indicate type of coverage:
☐ Hospital ☐ Extended Health ☐ Dental
☐ Vision ☐ Drugs ☐ Travel
☑ All

Was treatment the result of an accident? ( ) Yes (•) No

Please note: *this site is only able to store one bank account on file.*

Branch #	Bank #	Account #
12345	670	1234567


Click on cheque to enlarge image

Attach File (s) [ ] Browse...

Please read and accept the Terms and Conditions

By submitting a claim using this online submission service, I declare the following:

I acknowledge that my claim is subject to my Health and Dental contract and that the expenses listed in my

« Prev Next »

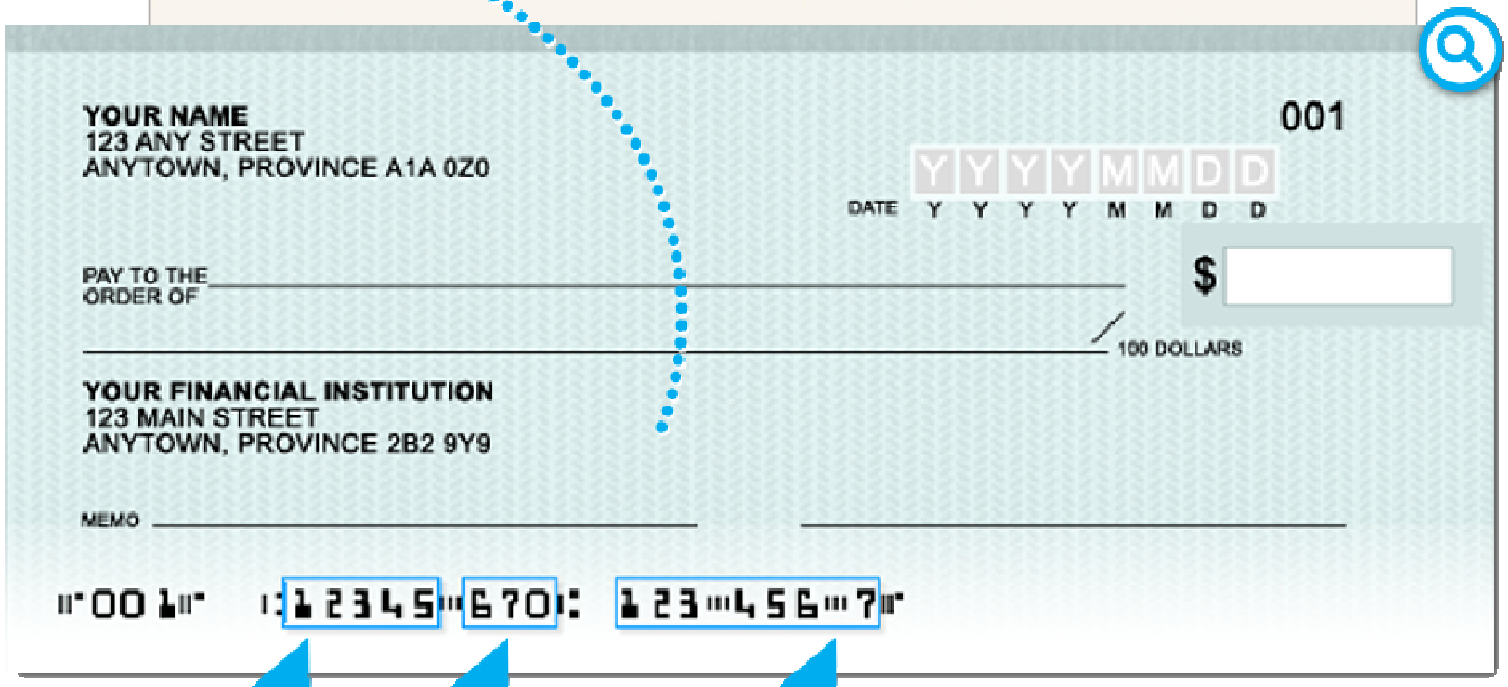
Vision Drugs Travel
All

Was treatment the result of an accident? Yes No

Please note: this site is only able to store one bank account on file.

Branch #	Bank #	Account #
12345	670	1234567

Click on cheque to enlarge image



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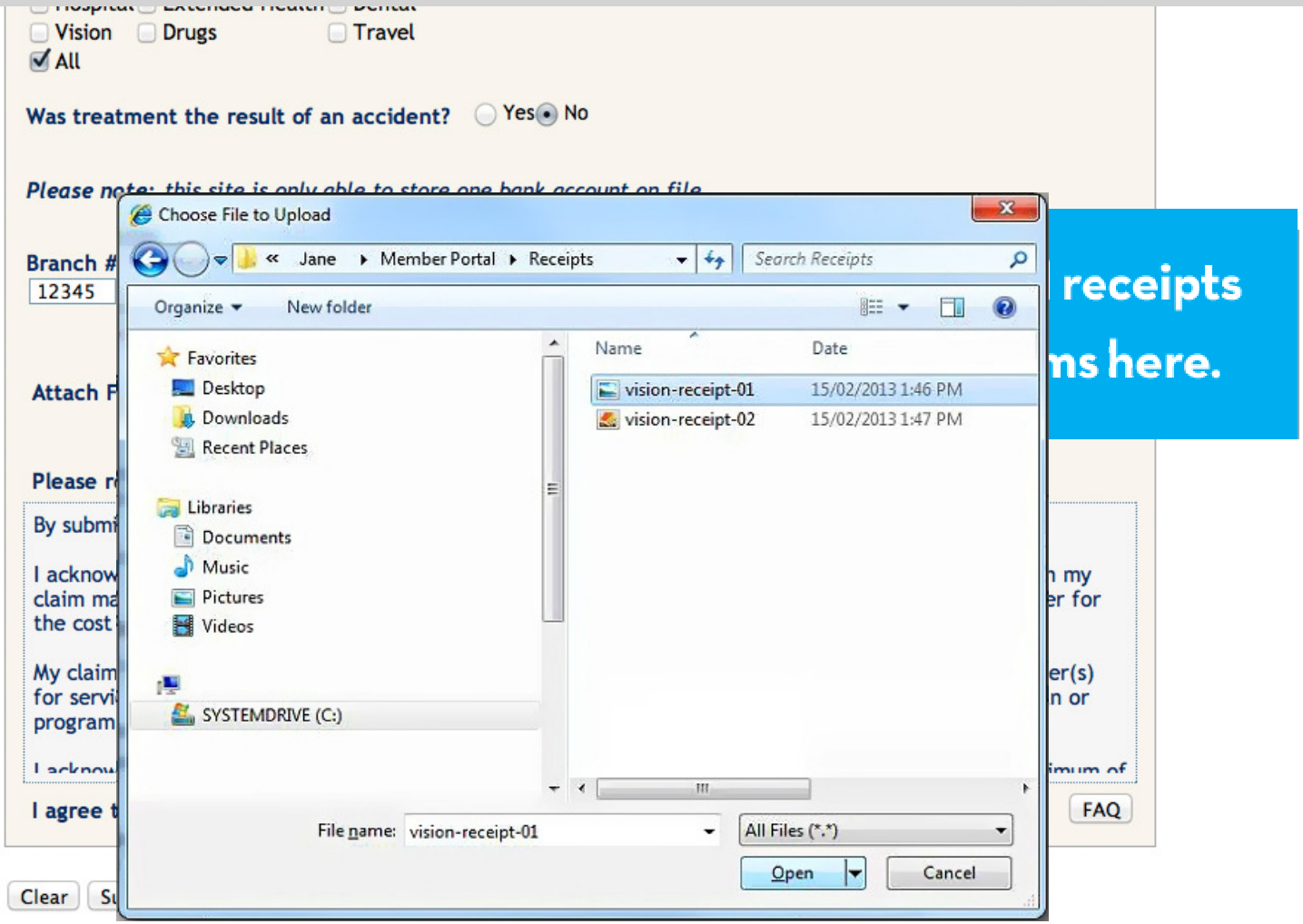
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Was treatment the result of an accident?
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Please note: this site is only able to store one bank account on file
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Desktop
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Documents
Music
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Videos
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vision-receipt-02
15/02/2013 1:47 PM
File name:
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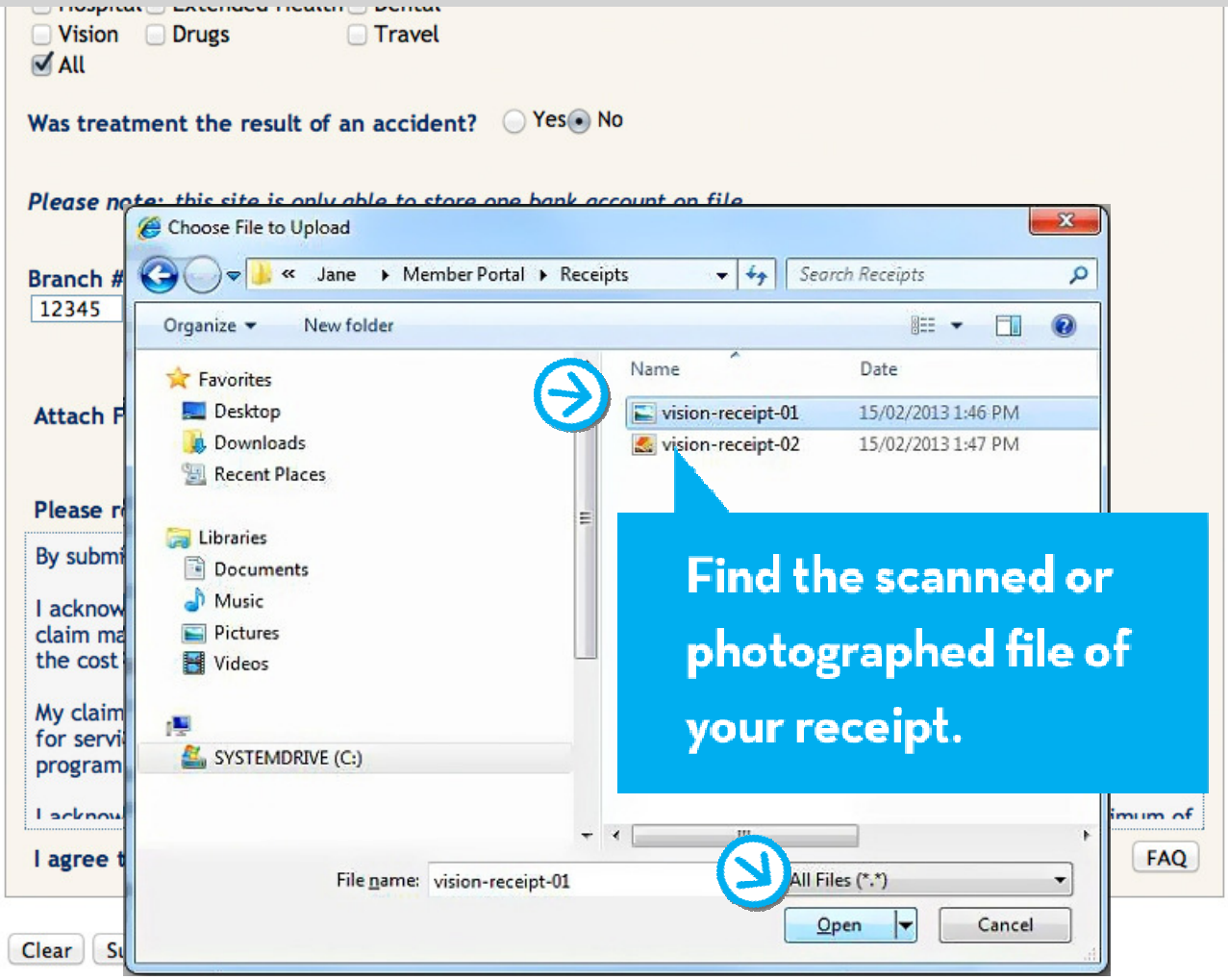
Vision
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Was treatment the result of an accident?
Yes
No
Branch #
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Member Portal
Receipts
Search Receipts
Organize
New folder
Favorites
Desktop
Downloads
Recent Places
Libraries
Documents
Music
Pictures
Videos
SYSTEMDRIVE (C:)
Name
Date
vision-receipt-01
15/02/2013 1:46 PM
vision-receipt-02
15/02/2013 1:47 PM
Find the scanned or photographed file of your receipt.
File name:
vision-receipt-01
All Files (*.*)
Open
Cancel

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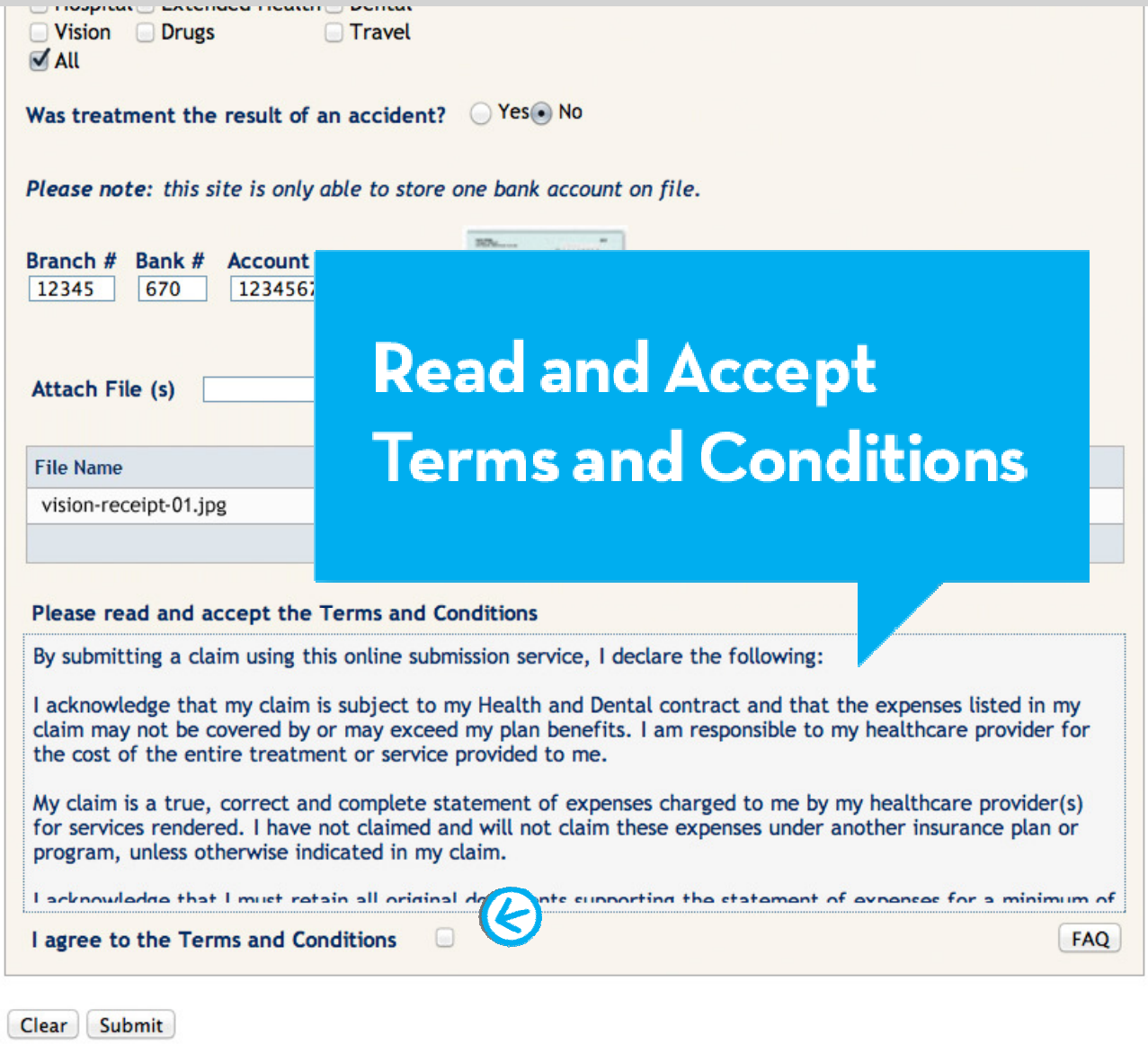
Vision
Drugs
Travel
All
Was treatment the result of an accident?
Yes
No
Please note: this site is only able to store one bank account on file.
Branch #
Bank #
Account
12345
670
Attach File (s)
File Name
vision-receipt-01.jpg
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I acknowledge that my claim is subject to my Health and Dental contract and that the expenses listed in my claim may not be covered by or may exceed my plan benefits. I am responsible to my healthcare provider for the cost of the entire treatment or service provided to me.
My claim is a true, correct and complete statement of expenses charged to me by my healthcare provider(s) for services rendered. I have not claimed and will not claim these expenses under another insurance plan or program, unless otherwise indicated in my claim.
I agree to the Terms and Conditions
FAQ
Clear
Submit
Read and Accept
Terms and Conditions

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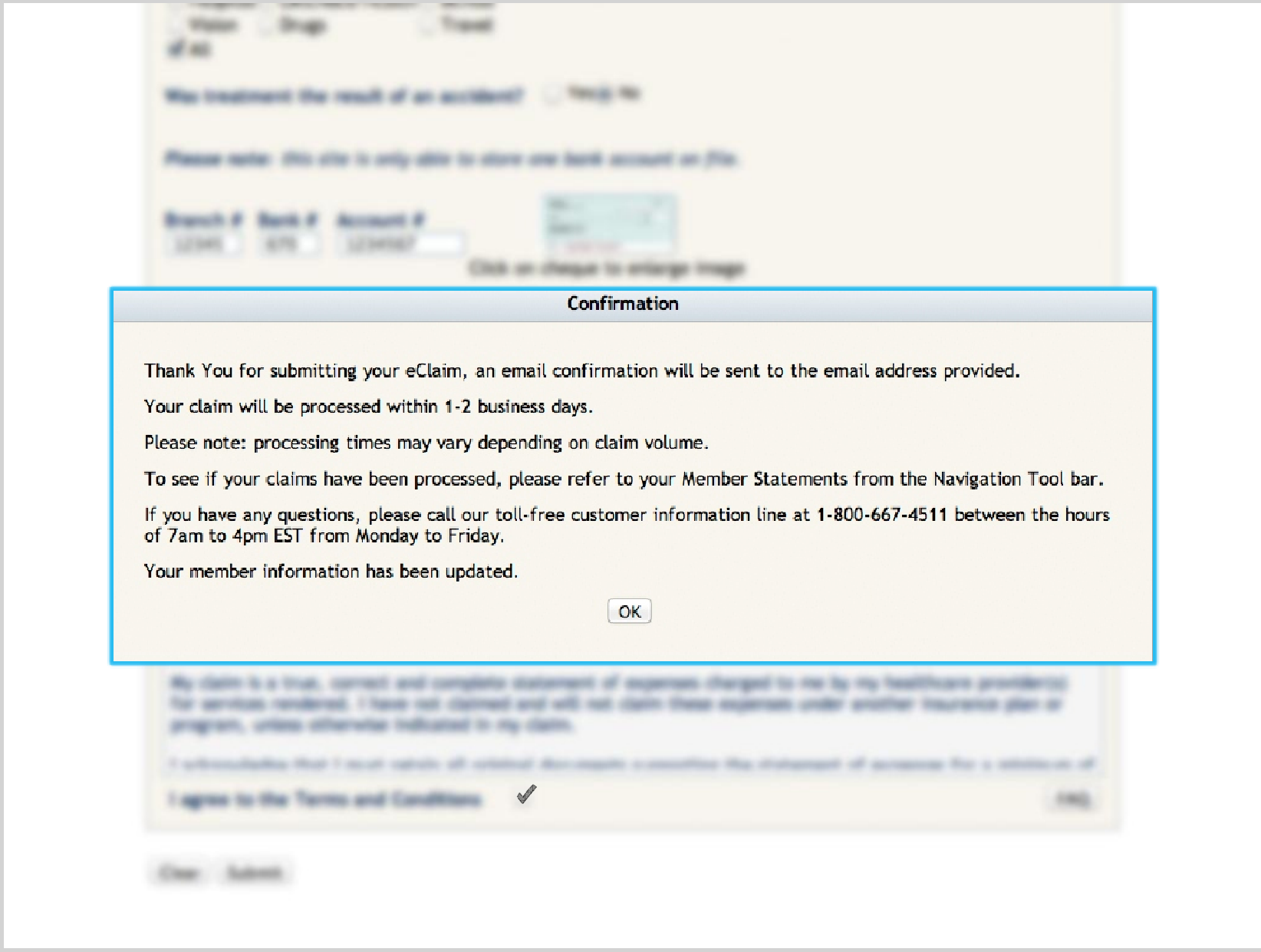
Confirmation
Thank You for submitting your eClaim, an email confirmation will be sent to the email address provided.
Your claim will be processed within 1-2 business days.
Please note: processing times may vary depending on claim volume.
To see if your claims have been processed, please refer to your Member Statements from the Navigation Tool bar.
If you have any questions, please call our toll-free customer information line at 1-800-667-4511 between the hours of 7am to 4pm EST from Monday to Friday.
Your member information has been updated.
OK

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Thank You.

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« Prev