MANITOBA BLUE CROSS®

GROUP TRAVEL HEALTH PLAN CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM:

- REFER TO YOUR GROUP AGREEMENT TO DETERMINE THE BENEFITS TO WHICH YOU MAY BE ENTITLED.
- PLEASE PRINT CLEARLY AND COMPLETE ALL QUESTIONS.
- RETAIN SECOND COPY OF THIS CLAIM FOR YOUR RECORDS.
- SUBMIT ORIGINAL FULLY ITEMIZED RECEIPTS OR INVOICES.

MANITOBA HEALTH #	PHIN #

CONTRACT NUMBER	GROUP NUMBER	PATIENT SURNAME	FIRST NAME	BIRTH DATE DAY MONTH YEAR

STREET, P.O. BOX NO	CITY/TOWN	PROVINCE	POSTAL CODE	HAS YOUR ADDRESS CHANGED IN THE LAST YEAR ◯ YES ◯ NO

EMPLOYER NAME

ARE ANY BENEFITS PROVIDED UNDER ANY OTHER INSURANCE PLAN?
◯ YES ◯ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURER

POLICY OR CONTRACT NUMBER

PERSON INSURED

DATE OF DEPARTURE FROM HOME PROVINCE

DATE OF ORIGINALLY SCHEDULED RETURN

DATE OF FIRST TREATMENT

MUST BE COMPLETED BY SUBSCRIBER

A WEEK OTHER THAN USUAL VACATION TIME AND PERFORMING ALL REGULAR DUTIES OF THAT OCCUPATION?
AT THE TIME OF CLAIM WERE YOU A FULL-TIME OR PERMANENT PART-TIME EMPLOYEE WORKING A MINIMUM OF 20 HOURS
◯ YES ◯ NO

DESCRIBE REASONS FOR SEEKING MEDICAL ATTENTION AND NATURE OF ILLNESS OR INJURY

ATTENDING PHYSICIAN:

NAME

COUNTRY:

FAMILY PHYSICIAN AT HOME:

NAME

ADDRESS

IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:

1. AGE OF CHILD
2. IS HE/SHE MARRIED? ◯ YES ◯ NO
   IF YES, DATE OF MARRIAGE DD MM YR
3. IS HE/SHE EMPLOYED FULL-TIME? ◯ YES ◯ NO
   IF YES, DATE FULL TIME EMPLOYMENT STARTED DD MM YR
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? ◯ YES ◯ NO
   NAME AND LOCATION OF COLLEGE OR UNIVERSITY
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ◯ YES ◯ NO

ARE INJURIES A RESULT OF AN ACCIDENT? ◯ YES ◯ NO IF YES, COMPLETE THE FOLLOWING:

TYPE OF ACCIDENT

DATE OF ACCIDENT

DETAILS OF ACCIDENT

LOCATION OF ACCIDENT

NAME AND ADDRESS OF LAWYER REPRESENTING YOU WITH RESPECT TO ACCIDENT

STATEMENT OF EXPENSES (ATTACH RECEIPTS)

FOR BLUE CROSS USE ONLY

	BILLING AGENCY	DATE OF SERVICE	TOTAL BILLED (FOREIGN FUNDS)	TOTAL BILLED (CANADIAN FUNDS)	PAID BY GOVERNMENT PLAN (CAN.)	PAID BY GOVERNMENT PLAN (U.S.)	MANITOBA BLUE CROSS BALANCE	RATE OF EXCHANGE
HOSPITAL OUT-PATIENT								
HOSPITAL IN-PATIENT								
MEDICAL CHARGES								
AMBULANCE								
PRESCRIPTION DRUGS								
OTHER								
TOTAL								TOTAL

BLUE CROSS USE ONLY BENEFIT CODE ASSESSED BY APPROVED BY DATE

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE CONTRACT. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGNAL. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF SERVICES RECEIVED.

DATE RES. PHONE BUS. PHONE

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____

IF THERE IS A CHARGE FOR COMPLETING THIS FORM IT IS THE RESPONSIBILITY OF THE INDIVIDUAL CLAIMING THE BENEFIT.

NAME AND ADDRESS OF PARTY TO WHOM PAYMENT IS TO BE MADE.

NAME

ADDRESS

ADDRESS POSTAL CODE

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