MANITOBA BLUE CROSS®

EXTENDED HEALTH BENEFITS CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM. FAMILY MEMBERS MAY SUBMIT A COMBINED CLAIM.

- COMPLETE THE CLAIM BY ENTERING THE APPROPRIATE AMOUNT IN THE SPACES BELOW.
- ENCLOSE ITEMIZED RECEIPTS FOR EACH SERVICE.
- RECEIPTS WILL NOT BE RETURNED — PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.
- FOR BENEFITS ASSIGNED TO PROVIDERS, ENCLOSE ITEMIZED STATEMENTS FOR EACH SERVICE.
- CLAIMS MUST BE SUBMITTED WITHIN 2 YEARS OF DATE OF SERVICE, UNLESS OTHERWISE STATED IN POLICY PROVISIONS.
- PLEASE RETAIN OUR EXPLANATION OF BENEFITS FOR COORDINATION OF BENEFITS OR INCOME TAX PURPOSES.

GROUP	BLUE CROSS CONTRACT NO.	SURNAME	CLAIMANT FIRST NAME	BIRTH DATE DAY / MONTH / YEAR

STREET, P.O. BOX NO	CITY/TOWN	PROVINCE	POSTAL CODE	HAS YOUR ADDRESS CHANGED? ◯ YES ◯ NO

WAS TREATMENT THE RESULT OF
AN INJURY AT THE WORK PLACE? ☐ YES ☐ NO
A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?

◯ YES ◯ NO IF YES, COMPLETE THE FOLLOWING

POLICY HOLDER OF OTHER PLAN

BIRTH DATE / / DAY MONTH YEAR

EMPLOYER

EMPLOYER'S INSURANCE COMPANY

POLICY OR CONTRACT NUMBER

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER AND COPIES OF THE RECEIPTS.

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
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ◯ YES ◯ NO

BENEFITS CLAIMED		TOTAL AMOUNT	BENEFITS CLAIMED		TOTAL AMOUNT
DRUGS (ENCLOSE OFFICIAL PHARMACARE RECEIPTS OR A PHOTOCOPY)					
OTHERS (PLEASE SPECIFY)					

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?

◯ YES ◯ NO

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:

PROVIDER NUMBER

NAME

ADDRESS

POSTAL CODE

I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT.

SUBSCRIBER'S SIGNATURE _____

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.

SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN) _____

(PLEASE SIGN HERE)

DATE

BLUE CROSS OFFICE USE ONLY

RECEIVED	ASSESSED
DATE:	DATE:
CHECKED	**AUDIT**
DATE: INIT.	DATE: INIT.

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