HOW TO COMPLETE YOUR CLAIM FOR EXTENDED HEALTH BENEFIT EXPENSES

1 Complete all the member information in Section 1 and Section 2 (*Self*). If you are claiming for your spouse, and/or dependents, please include them in Section 2.

2 **Every receipt you are submitting must be indicated in Section 4 with all corresponding fields completed or the form will be sent back for you to complete and sign.** Out-of-country expenses must be claimed on a separate *Alberta Blue Cross Travel Claim Form* and dental services, including accidental dental claims, must be claimed using the *Alberta Blue Cross Dental Claim Form*.


BLUE CROSS

HEALTH SERVICES CLAIM

1 MEMBER INFORMATION

252	II	DOE	JOHN

555 ANYWHERE AVENUE — 780-555-5050

ANYTOWN — AB — T1T 5T5

2 COMPLETE FOR MEMBER AND ALL PERSONS BEING CLAIMED FOR ON THIS FORM

Self	987654321	JOHN	1963 04 12
Spouse	987654322	JANE	1964 09 17

3 OTHER COVERAGE

4 CLAIM INFORMATION

2009	01	23	Prescription drugs	000002229999	$47.83
2009	01	10	Psychology Counselling		$130.00

ENTER TOTAL CLAIM AMOUNT > $ 177.83

5 ACKNOWLEDGEMENT AND CONSENT

John Doe

March 10, 2009

PLEASE SEE REVERSE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO:
ALBERTA BLUE CROSS, HEALTH SERVICES,
10009 - 108 STREET NW, EDMONTON AB T5J 3C5

3 This section must be completed, even if you only check the "No" box. If, however, you, your spouse, or any dependents are entitled to receive comparable benefits for the expense or services being claimed from any other health benefit plan (including another Blue Cross plan), the remainder of Section 3 (*Other Coverage*) must be completed.

4 Please ensure you have read and understood Section 5, *Acknowledgement and Consent*. In doing so, the member should ensure that:

- all individuals for whom this claim is made are eligible under his/her plan, and
- your spouse and eligible adult dependents are aware and have authorized the member to disclose and receive information about their claims made under this plan.

5 By submitting this claim form, the member, spouse and eligible adult dependents who are claiming agree to the provisions of the *Acknowledgement and Consent*.

RECEIPTS

1. Attach original paid receipts for each expense claimed and **keep copies for your records, as these receipts will not be returned**. If you have claimed these expenses under another plan, the original Explanation of Benefits (see explanation) from that plan and **copies** of receipts **must** be attached to this claim. All original receipts must indicate the following information: first and last name of individual receiving the service, date or dates on which the service was obtained, the service or product purchased, the provider of service's name and address and the amount charged and paid.

NOTE: Receipts/invoices with incomplete information will be rejected.

OTHER COVERAGE (Coordination of Benefits)

Coordination of Benefits (COB) is a standard practice among benefit carriers in Canada. COB allows people with more than one plan to maximize their coverage.

If you are claiming expenses for your spouse and your spouse is covered for those expenses under another health benefit plan, you must submit the claim to your spouse's plan first. If both you and your spouse have health benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first.

EXPLANATION OF BENEFITS AND CLAIMS PAYMENT

An Explanation of Benefits statement, indicating how this claim was assessed, will be sent to the member to be used for income tax purposes or to claim under other coverage. If you are being reimbursed, a cheque will accompany the statement. If your claim is complete with all the necessary receipts and documents, the Explanation of Benefits and cheque (if appropriate) will be mailed approximately two weeks after we receive your claim.

EDMONTON	780-498-8000
CALGARY	403-234-9666
GRANDE PRAIRIE	780-532-3505
LETHBRIDGE	403-328-1785
MEDICINE HAT	403-529-5553
RED DEER	403-343-7009

Toll free from areas outside these major centres:

1-800-661-6995

Questions about privacy? 780-498-8100 ext. 8108

Visit our web site at: **www.ab.bluecross.ca**

MAIL YOUR CLAIM TO:

Alberta Blue Cross
Health Services
10009 – 108 Street NW
Edmonton, AB T5J 3C5

ALBERTA BLUE CROSS®

10009 - 108 Street NW, Edmonton, Alberta T5J 3C5

SHADED AREA FOR BLUE CROSS USE ONLY

HEALTH SERVICES CLAIM

*All sections must be completed before your claim can be processed. This includes Section 3, *Other Coverage.*

1. MEMBER INFORMATION * (Refer to your I.D. card)

GROUP NO.	SECTION	MEMBER'S LAST NAME	FIRST NAME

MEMBER'S MAILING ADDRESS	PHONE NO. (During business hrs)

CITY	PROVINCE	POSTAL CODE

Has the mailing address changed since the last claim was made under this coverage?
☐ **No** ☐ **Yes**

If Yes, the member (in whose name the coverage is registered) must validate that the address has changed.

MEMBER'S CONFIRMATION
(please sign)

2. COMPLETE FOR MEMBER AND ALL PERSONS BEING CLAIMED FOR ON THIS FORM *

RELATIONSHIP TO MEMBER	I.D. NUMBER	FIRST NAME	LAST NAME (If different from above)	BIRTHDATE YYYY	MM	DD
Self	–					
Spouse	–					
	–					
	–					
	–					

3. OTHER COVERAGE *

Are you or your dependents entitled to receive comparable benefits from any other insurance company, health benefits company or Alberta Blue Cross plan?

☐ **No** ☐ **Yes** - If yes, complete the following:

NAME OF INSURANCE COMPANY OR OTHER HEALTH BENEFITS COMPANY OR, IF OTHER BLUE CROSS COVERAGE, NAME OF EMPLOYER

NAME OF INSURED / MEMBER

DATE OF BIRTH YYYY / MM / DD

POLICY IDENTIFICATION NUMBER OR BLUE CROSS GROUP, SECTION & ID NUMBER

EFFECTIVE DATE YYYY / MM / DD

CANCELLATION DATE YYYY / MM / DD

4. CLAIM INFORMATION * (Please follow instructions, see reverse)

	DATE OF SERVICE YYYY	MM	DD	SERVICE DESCRIPTION or PRESCRIPTION NUMBER	D.I.N. (Prescriptions only)	AMOUNT CLAIMED
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
				ENTER TOTAL CLAIM AMOUNT >		**$**

5. ACKNOWLEDGEMENT AND CONSENT *

By submitting this Health Services Claim ("Claim") for processing and payment by Alberta Blue Cross, and in consideration of Alberta Blue Cross processing/paying this claim, I/we consent and/or agree to/with the following provisions:

- The identified services have been received and fully paid for prior to the date of this Claim.
- All information contained in this claim and any supporting documents is complete and true.
- All personal information contained in this Claim, as well as other personal information currently held or collected in the future by Alberta Blue Cross, will be used by Alberta Blue Cross only to determine eligibility for benefits, to assess/pay claims, to administer the terms of my/our benefit plan and to verify/audit paid claims.
- My/our or my dependents' personal information may be disclosed/exchanged only between Alberta Blue Cross and a licensed physician and/or health services provider/professional/practitioner, institution or insurer, only for the purposes stated above; and my/our and my dependents' personal information will otherwise be kept confidential and secure.
- The Member is authorized by his/her spouse and/or other adult dependents to disclose/receive information about them that is used solely for these purposes.
- For the purpose of verifying/auditing paid claims, I/we and any spouse/eligible dependent(s) will co-operate fully with Alberta Blue Cross.
- I/we understand why my/our and my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above.
- I/we have read and understood this Acknowledgement and Consent and understand that Alberta Blue Cross is relying on this signed Acknowledgement and Consent when assessing (and paying) this Claim.
- I/we authorize Alberta Blue Cross to collect, use and disclose my/our and my dependents' personal information as described above.
- I/we agree that this Acknowledgement and Consent shall be effective from the date of Claim and shall remain in effect as long as the coverage is in force.

Signature of Member

Date

Signature of Patient/Claimant (or Parent/Guardian)

Date

Note: This consent is obtained in accordance with Alberta's *Health Information Act* and *Personal Information Protection Act* and the federal Personal Information Protection and Electronic Documents Act. I/we – refers to the one or more individuals signing and/or submitting this form.

PLEASE SEE REVERSE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO ALBERTA BLUE CROSS, HEALTH SERVICES, 10009 - 108 STREET NW, EDMONTON AB T5J 3C5