ALBERTA BLUE CROSS®

10009 108 Street NW, Edmonton, Alberta T5J 3C5

HEALTH SERVICES CLAIM

All sections must be completed before your claim can be processed. *This includes other coverage.

Member information* (*refer to your ID card*)

Group	Section	Last name	First name	Phone number (*during business hours*)

Member's mailing address	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 confirmation (please sign)** _____

Complete for member and all persons being claimed for on this form*

Relationship to member	ID number	First name	Last name (if different from above)	Date of birth		
Self				YYYY	MM	DD
Spouse				YYYY	MM	DD
Dependant				YYYY	MM	DD
Dependant				YYYY	MM	DD
Dependant				YYYY	MM	DD

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 member, name of insurance company or other health benefits company or, if other Alberta Blue Cross coverage, name of employer	Date of birth		
	YYYY	MM	DD

Policy ID number or Alberta Blue Cross group, section and ID number	Effective date			Cancellation date		
	YYYY	MM	DD	YYYY	MM	DD

Please ensure you fill out the **claim and signature section on next page** ➔

Receipts (*NOTE: Receipts and invoices with incomplete information will be rejected)*

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 service provider's name and address and the amount charged and paid.

Other coverage

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

1. 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? Call 1-855-498-7302, contact us through our web site or write to Privacy Matters at the address on this form. 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

Claim information (*please follow instructions, see reverse*)

	Date of service			Service description or prescription number	D.I.N. *(prescriptions only)*	Amount claimed
1	YYYY	MM	DD			
2	YYYY	MM	DD			
3	YYYY	MM	DD			
4	YYYY	MM	DD			
5	YYYY	MM	DD			
6	YYYY	MM	DD			
7	YYYY	MM	DD			
8	YYYY	MM	DD			
9	YYYY	MM	DD			
10	YYYY	MM	DD			
11	YYYY	MM	DD			
12	YYYY	MM	DD			
13	YYYY	MM	DD			
14	YYYY	MM	DD			
15	YYYY	MM	DD			
16	YYYY	MM	DD			
17	YYYY	MM	DD			
18	YYYY	MM	DD			
19	YYYY	MM	DD			
					Enter total claim amount	**$**

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

Acknowledgement and consent*

By submitting this health services 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 and pay claims, to administer the terms of my/our benefit plan and to verify or audit paid claims.
- My/our or my dependants' personal information may be disclosed or exchanged only between Alberta Blue Cross and a licensed physician and/or health services provider/professional/practitioner, institution or insurer for the purposes stated above My/our and my dependants' personal information will otherwise be kept confidential and secure.
- The member is authorized by his/her spouse and/or other adult dependants to disclose and receive information about them that is used solely for these purposes.
- For the purpose of verifying or auditing paid claims, I/we and any spouse/eligible dependant(s) will co-operate fully with Alberta Blue Cross.
- I/we understand why my/our and my dependants' 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 dependants' 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 primary plan member	Date			Signature of Patient/Claimant (or Parent/Guardian)
	YYYY	MM	DD	

This consent is obtained in accordance with Alberta's Health Information Act, the 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.