

# HEALTH BENEFITS CLAIM FORM

Active Employees

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

- PLEASE ATTACH ITEMIZED RECEIPTS/INVOICES AND PRESCRIPTIONS/REFERRALS (IF REQUIRED). A COPY OF A VALID PRESCRIPTION IS REQUIRED FOR VISION CLAIMS.
- RECEIPTS WILL NOT BE RETURNED.
- CLAIMS MUST BE SUBMITTED WITHIN 18 MONTHS OF DATE OF SERVICE, UNLESS OTHERWISE SPECIFIED IN POLICY PROVISIONS.

## MEMBER INFORMATION

Contract/Certificate Number		Group/Client Number <b>41480</b>	Has your address changed? Yes <input type="checkbox"/> No <input type="checkbox"/> Your plan requires address changes be requested through your employer.
Last Name	First Name		Are any expenses the result of an accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please complete the following:
Address			Where did the accident occur? Work <input type="checkbox"/> Vehicle <input type="checkbox"/> Other <input type="checkbox"/>
City	Province	Postal Code	Accident details: (if extra space is required, attach an additional page)
Email Address/Phone Number			

## SERVICE RECIPIENT (PATIENT) INFORMATION

For additional service recipients, please use another claim form.

Service Recipient's Name	Birth Date (dd/mm/yyyy)	Relationship to Member	Total Amount Claimed (\$)

## COORDINATION OF BENEFITS

**A.** Are any benefits provided under another Manitoba Blue Cross Plan? Yes  No   
If yes, please provide the certificate number of the other plan \_\_\_\_\_

**B.** Are any benefits provided under any other insurance carrier? Yes  No   
If yes, please provide the following information:  
Name of the other insurance carrier \_\_\_\_\_ Policyholder name \_\_\_\_\_  
Effective date of coverage \_\_\_\_\_ Are all family members covered under this policy? \_\_\_\_\_  
If no, please indicate which members are covered: \_\_\_\_\_  
What coverage does the other plan provide?  Ambulance  Dental  Health  Hospital  Prescription Drugs  Vision  HSA

## COMPLETE THIS SECTION ONLY IF PAYMENT IS TO BE MADE TO THE SERVICE PROVIDER

Provider Number: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City & Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

## AUTHORIZATION AND CONSENT

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 provider for the cost of the treatment(s). I also 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.

Member or Service Recipient Signature \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION & CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or [mb.bluecross.ca](http://mb.bluecross.ca) should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

## HOW TO SUBMIT YOUR CLAIM

Online: mybluecross@ account  
at [mb.bluecross.ca](http://mb.bluecross.ca)

In Person/  
Drop Box: 599 Empress Street  
Winnipeg, MB

Mail: PO Box 1046 Stn Main  
Winnipeg MB R3C 2X7

Fax: 204.772.1231

**Inquiries?** Email through Contact Us at [mb.bluecross.ca](http://mb.bluecross.ca) or phone 204.775.0151 or 1.888.596.1032 (toll free)

