MANITOBA BLUE CROSS®

WCB Workers Compensation Board of Manitoba

HEALTH BENEFITS CLAIM FORM

Retirees Prior to March 1, 2015

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	
4400	41480	**Has your address changed?** Yes ☐ No ☐ **Your plan requires address changes be requested though your employer.**
Last Name	First Name	Are any expenses the result of an accident? Yes ☐ No ☐ If Yes, please complete the following:
Address		Where did the accident occur? Work ☐ Vehicle ☐ Other ☐
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 <u>ONLY</u> 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 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	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 or phone 204.775.0151 or 1.888.596.1032 (toll free)