MANITOBA BLUE CROSS®

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

HEALTH BENEFITS CLAIM FORM

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 TWO YEARS OF DATE OF SERVICE, UNLESS OTHERWISE SPECIFIED IN POLICY PROVISIONS.

MEMBER INFORMATION

Contract/Certificate Number Group/Client Number	**Has your address changed?** Yes ❑ No ❑ Some plans require address changes be requested through the employer only.
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 contract/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: _____

HEALTHCARE SPENDING ACCOUNT (if applicable)

❑ **Check here if you would like to request any unpaid balances from this claim to be paid using your Healthcare Spending Account**

You must claim all medical expenses through your provincial and group insurance plans before payment can be made from a Healthcare Spending Account. Only medical expenses recognized by Canada Revenue Agency are eligible, and payments will only be issued to the member.

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_____
(or Parent/Guardian)

Please see reverse for contact information and how to submit your claim.

Received 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 my personal information will be kept confidential and secure. 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 1.800.873.2583 or www.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: www.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

CONTACT INFORMATION

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

E-Mail: info@mb.bluecross.ca for general inquiries

In Person: 599 Empress Street
Winnipeg MB
Monday to Friday 9:00 a.m. to 5:30 p.m.

Website: www.mb.bluecross.ca

Telephone: 204.775.0151 in Winnipeg
1.800.873.2583 in Manitoba
1.888.596.1032 outside Manitoba
Monday to Friday 8:00 a.m. to 5:30 p.m.