

HOW TO CLAIM FOR EXTENDED HEALTH BENEFIT EXPENSES

To ensure prompt handling of your claim, please carefully follow these instructions.

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

COMPLETING THE FORM

1. Please make sure you have clearly filled in all the information completely (PLEASE PRINT) and signed the form. All sections must be completed before your claim can be processed. This includes Section 3, *Other Coverage*.
2. Complete all the subscriber information in Section 1 and Section 2 (*Self*).
3. If you are claiming for your spouse, and/or dependents, please include them in Section 2.
4. If 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), Section 3 (*Other Coverage*) must be completed.
5. Complete Section 4 as follows:
 - a) Every receipt you are submitting must be indicated in Section 4 with all corresponding fields completed.
 - b) For prescription drugs, indicate the Date of Service, prescription number, Drug Identification Number (*DIN*) and claimed amount, as shown on your receipts.
 - c) For other expenses:
 - Clearly indicate the service being claimed and complete all fields, including the total amount claimed. Include all supporting documents, as specified in your benefit booklet (e.g. physician's written order).
 - Out-of-country expenses must be claimed on a separate *Alberta Blue Cross Travel Claim Form*.
 - For all dental services, including accidental dental claims, please use the *Alberta Blue Cross Dental Claim Form*.
6. Please read, sign and date Section 5.

ORIGINAL RECEIPTS REQUIRED

1. Attach original receipts for each expense claimed and **keep copies for your records**. 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.
2. 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. These receipts become part of our records and will not be returned.
3. Receipts must be submitted to Alberta Blue Cross within your group's claiming limitation. (A specific period of time to submit expenses. Refer to your benefit information.)

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.

1. 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.
2. 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 subscriber 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. Please retain the statement and cheque stub as no other statements will be issued.

For assistance call the nearest Alberta Blue Cross office. All inquiries should be made within 30 days of receiving the reimbursement cheque.

EDMONTON	(780) 498-8000
CALGARY	(403) 234-9666
FORT MCMURRAY	(780) 790-3390
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**

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

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

GROUP NO.	SECTION	SUBSCRIBER'S LAST NAME	FIRST NAME
SUBSCRIBER'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? <input type="checkbox"/> No <input type="checkbox"/> Yes		If Yes , the subscriber (in whose name the coverage is registered) must validate that the address has changed.	
		SUBSCRIBER'S CONFIRMATION (please sign)	

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

RELATIONSHIP TO SUBSCRIBER	IDENTIFICATION NUMBER	FIRST NAME	LAST NAME (If different from above)	BIRTHDATE		
				YYYY	MM	DD
Self	-					
Spouse	-					
	-					
	-					
	-					

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

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

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**

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

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 / SUBSCRIBER

DATE OF BIRTH
YYYY / MM / DD

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

EFFECTIVE DATE
YYYY / MM / DD

CANCELLATION DATE
YYYY / MM / DD

5. ACKNOWLEDGEMENT AND CONSENT *

I/we certify that the information contained in this and other documents supporting this claim is true and complete. I/we understand that the personal information provided herein about me and eligible dependents, as well as personal information currently held or collected in the future by Alberta Blue Cross, will be used to determine eligibility for benefits; verify, assess and pay claims; and manage my benefit plan. I/we certify that the subscriber is authorized by his/her spouse and/or other adult dependents (if applicable) to disclose and receive information about them that is used for these purposes.

I/we hereby acknowledge and agree that my/our/my dependents' personal information may be exchanged between Alberta Blue Cross and a licensed physician and/or any other health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I/we understand that my/our and my dependents' personal information will be kept confidential and secure. I/we understand that I/we may revoke this consent at any time and acknowledge that should I/we do so, my/our claim may not be considered. I/we understand why my/our/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 authorize Alberta Blue Cross to collect, use and disclose my/our/my dependents' personal information as described above.

Signature of Subscriber (required)

Date

Signature of Patient/Claimant (or Parent/Guardian)

Date

This consent is obtained in accordance with section 34 of Alberta's Health Information Act, sections 7, 8 and 9 of Alberta's Personal Information Protection Act and section 5 of the federal Personal Information Protection and Electronic Documents Act.