MEDAVIE BLUE CROSS™

VISION CLAIM FORM

PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS

MEMBER INFORMATION

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY) _____

Last Name: _____ First Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ☐ Yes ☐ No If yes, signature of member is required for validation: _____

OTHER COVERAGE

Do you or any of your dependents have other coverage under any other plan?

☐ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

☐ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ☐ **Individual** ☐ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ☐ Hospital ☐ Travel ☐ Extended Health ☐ Drugs ☐ Vision ☐ Dental ☐ **All**

MEMBER STATEMENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Signature: _____ Date (DD/MM/YYYY): _____

(If under 18 years of age the signature of the member is required.)

VISION CLAIM INFORMATION - To be completed by the Provider

Provider Name: _____ Provider No.: _____ Telephone: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

Is this a new patient? ☐ Yes ☐ No Are lenses required due to a medical condition/disease? ☐ Yes ☐ No

If Yes, state condition/disease: _____

Benefit Description		Date of Service DD/MM/YYYY *(Date Goods Paid-in-full)*	Charge *(Must be broken down by benefit description)*
Eye Examination			
Frame			
Lens	Right		
	Left		
Tinting			
UV Coating			
Anti-reflection Coating			
Plano Sunglasses			
Contact Lens	Right		
	Left		
Other *			
		TOTAL	

* Description of Other: _____

Details of this prescription

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					
ADD R					
ADD L					

Bifocal Type ☐ Round ☐ ST

If changed, details of last prescription

(This information is not required if this is a new patient)

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					
ADD R					
ADD L					

Bifocal Type ☐ Round ☐ ST

Type of Right Lens:

☐ Single ☐ Bifocal
☐ Multifocal ☐ Progressive
☐ Spherical ☐ Compound
☐ Hi Index ☐ Polycarbonate
☐ Aspheric ☐ Slaboff

Type of Left Lens:

☐ Single ☐ Bifocal
☐ Multifocal ☐ Progressive
☐ Spherical ☐ Compound
☐ Hi Index ☐ Polycarbonate
☐ Aspheric ☐ Slaboff

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: _____ Date: _____

MEDAVIE BLUE CROSS ADDRESSES

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