MEDAVIE BLUE CROSS™

NURSING / PERSONAL CARE CLAIM FORM

PLEASE PRINT ALL INFORMATION.
PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS FOR ALL SERVICES RENDERED.

SECTION 1 - TO BE COMPLETED AND SIGNED BY THE PATIENT (PARENT / GUARDIAN)

MEMBER INFORMATION

Member Name: _____ ID Number: _____

Address: _____ Policy Number: _____

Telephone Number: _____

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____

Contact Name: _____ Contact Telephone Number: _____

Is the patient a resident of: ☐ Nursing Facility ☐ Special Care Home ☐ Not Applicable

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 dependents have 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 of Patient: _____ Date (DD/MM/YYYY): _____

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

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces
644 Main St PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Quebec
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

Ontario
PO Box 2000 STN A
Etobicoke ON M9 C5P1
Inquiries: 1-800-667-4511

Other Provinces and Territories
PO Box 2318 STN Main
Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511

SECTION 2 ON REVERSE PAGE TO BE COMPLETED BY ATTENDING PHYSICIAN AND SECTION 3 ON REVERSE PAGE TO BE COMPLETED BY NURSING/PERSONAL CARE PROVIDER

SECTION 2 - TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(If all applicable information was provided by the physician in the past 12 months, completion of this section is not required)

DIAGNOSIS INFORMATION

Primary Diagnosis: _____

Other Pertinent Diagnosis: _____

Description of Prescribed Medical Services: _____

_____

_____

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I prescribed private duty nursing / personal care service for the above named patient, due to the seriousness of the patient's illness.

Physican Name (Please Print): _____

Address: _____

Physician Signature: _____ Date: _____

SECTION 3 - TO BE COMPLETED BY THE NURSING / PERSONAL CARE PROVIDER

PROVIDER INFORMATION

Agency Name (if applicable): _____ Provider Number: _____

Address: _____ Telephone Number: _____

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: _____

REGISTERED NURSING / PERSONAL CARE CHARGES

*** Please indicate shift worked: (i.e. 0800 - 1600; 1600 - 2400; 2400 - 0800 hrs.)**

Provider Name	Designation (RN, RNA, LPN, PCW)	Registration Number	Date of Service			Shift * Start	Shift * Finish	Total # of Hours	Total Amount charged per shift	Location		
			DD	MM	YYYY					Home	Hosp.	Clinic or Other (Please Specify)

Description of Service Rendered

Nursing Care

Services Provided - Please indicate (✓) all services rendered:

- ☐ ADL's
- ☐ Bloodwork
- ☐ Dressings
- ☐ Meals / Housekeeping
- ☐ Supervision / Monitoring
- ☐ Injections
- ☐ Medication Administration
- ☐ Ostomy
- ☐ Custodial Care / Respite
- ☐ Shopping / Transportation
- ☐ Footcare
- ☐ Vitals
- ☐ Services in Hospital / Nursing Home

☐ Other (Please specify): _____

*** PLEASE ENSURE ALL AREAS ARE COMPLETE. INCOMPLETE INFORMATION MAY DELAY PROCESSING.**

*** PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS FOR THE ABOVE SERVICES.**