MEDAVIE BLUE CROSS™

NEXUS® NETWORK

MANAGING CHRONIC DISEASE CLAIM FORM

MEMBER INFORMATION

ID Number: _____ Policy Number: _____

Provincial Health Plan No. (applies only to BC and SK residents): _____ Date of Birth (DD/MM/YYYY): _____

Last Name: _____ First Name: _____

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

Home Telephone No.: ( ) _____ Work Telephone No.: ( ) _____

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 coverage under any other plan?

◯ No If applicable, please provide the termination date (dd/mm/yyyy): _____

◯ Yes **If Yes, complete the following:**

Name of other Insurer: _____

Member Name: _____

ID Number: _____ Policy Number: _____

Type of policy (✓): ◯ **Individual** ◯ **Group** Effective Date: _____

Please indicate type of coverage (✓) :

☐ Hospital ☐ Travel ☐ Extended Health ☐ Drugs ☐ Vision ☐ Dental ☐ All

OTHER INFORMATION

Was the treatment the result of an accident? ◯ Yes ◯ No

If yes, please complete the following and attach details of the accident.

Was treatment the result of an injury in the workplace? ◯ Yes ◯ No

If yes, has Worker's Compensation been advised? ◯ Yes ◯ No

MEMBER STATEMENT

I certify that I have not claimed and will not claim these expenses under any other insurance plan (unless indicated above), and that all information contained herein is correct.

I hereby authorize the release of any information or records requested in respect to this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by my Blue Cross plan may be collected, used, or disclosed to administer and manage the terms of my plan or the group plan of which I am an eligible member or dependent, to recommend suitable products and services to me, and to manage my Blue Cross plan's business. For the purposes listed above, limited personal information may be collected from and/or released to a third party. This third party may include another Blue Cross organization, a licensed physician, health care professional or institution, life and health insurer, government and regulatory authorities, the member of any plan under which I am a dependent or another third party.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent my Blue Cross plan from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize my Blue Cross plan to collect, use and disclose my personal information as described above.

Signature _____ Date _____

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

This consent complies with federal and provincial privacy laws. For additional information regarding your Blue Cross plan's privacy policies, call 1-888-873-9200.

DETAILS OF CLAIM - To be completed by provider

Provider Name _____ Provider No. _____ Telephone _____

Address _____ City _____ Prov. _____ Postal Code _____

Patient Name: _____ **Diagnosis**: _____

Date of Service DD	MM	YYYY	Description of Services/Products	Charges
				$
FOR INTERNAL USE: Benefit Code 0390 with applicable sub-code.			**Total Charges:**	$

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 pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: **X** _____ Date: _____

ADDRESSES

Atlantic Canada
PO Box 220
644 Main St
Moncton NB E1C 8L3

Quebec
550 Sherbrooke West
PO Box 3300,
Postal Station B
Montreal QC H3B 4Y5

Ontario
PO Box 2000
185 The West Mall
Suite 1200
Etobicoke ON M9C 5P1

Manitoba
PO Box 1046
Winnipeg MB R3C 2X7

Saskatchewan
PO Box 4030
516 2nd Avenue N
Saskatoon SK S7K 3T2

Alberta
PO Box 2318 STN Main
Edmonton AB. T5J 0L8

British Columbia
PO Box 7000
Vancouver BC V6B 4E1

** Each plan is an independent licensee of the Canadian Association of Blue Cross Plans.*

INQUIRIES: 1-888-873-9200

*** Please ensure all areas are complete. Incomplete information may delay processing.**
*** Please attach all original paid-in-full receipts.**