

HEALTH SPENDING ACCOUNT/ PERSONAL WELLNESS ACCOUNT

MEMBER INFORMATION											
1[Number:				Policy N	umber:					
					Date of Birth (DD/MM/YYYY):						
Δ	.ddress:										
City:			Province:	Postal Cod	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:											
C	THER 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: Type of policy (/): Individual Group Effective Date: Policy Number: Please indicate type of coverage (/): Hospital Travel Extended Health Drugs Vision Dental										
A D	HEALTH SPENDING ACCOUNT / PERSONAL WELLNESS ACCOUNT SELECTION All eligible services will be assessed under your base plan. Do you want this claim processed through your Health Spending Account? Do you want this claim processed through your Personal Wellness Account? Yes No										
		CLAIM INFORMATION									
	CLAIM INFORMATIO	N									
	CLAIM INFORMATIO		RELATIONSHIP TO MEMBER	DA	TE OF BII	RTH	TYPE OF SERVICE	DAT	E OF SER	VICE	AMOUNT PAID
			RELATIONSHIP TO MEMBER Self, Spouse, Child	DA	TE OF BII	?TH year	TYPE OF SERVICE	DAT day	E OF SER	e VICE year	AMOUNT PAID
	CLAIMAN	T'S NAME					TYPE OF SERVICE				AMOUNT PAID
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	CLAIMAN	T'S NAME							month	year	AMOUNT PAID
33 4 4 5 6 1	CLAIMAN	Last Name Last Name						day	month	year	AMOUNT PAID
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MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces Quebec Ontario Other Provinces and Territories PO Box 220 PO Box 3300 STN B PO Box 2000 STN A PO Box 2318 STN Main Montreal QC H3B 4Y5 Moncton NB E1C 8L3 Etobicoke ON M9C 5P1 Edmonton AB T5J OL8 Inquiries: 1-800-667-4511 Inquiries: 1-800-667-4511 Inquiries: 1-800-667-4511 Inquiries: 1-800-667-4511

- Please ensure all areas are complete. Incomplete information may delay processing.
 Please attach all original paid-in-full receipts or an EOB from the primary carrier and photocopies of receipts.
- * Prescription drug receipts must indicate: name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.
 * Original receipts will not be returned.
- * All receipts should indicate: name of supplier/provider, item/service rendered, provider telephone number.



