ALBERTA BLUE CROSS®

HEALTH SERVICES CLAIM

10009 108 Street NW, Edmonton, Alberta T5J 3C5

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

Member information* (*refer to your ID card*)

Group/policy	Section	Last name	First name	Phone number (*during business hours*)

Member's mailing address	City	Province	Postal code

Has the mailing address changed since the last claim was made under this coverage? ☐ No ☐ Yes	**If yes**, the member *(in whose name the coverage is registered)* must validate that the address has changed.	**Member confirmation (please sign)** _____

Complete for member and all persons being claimed for on this form*

Relationship to member	ID number	First name	Last name (if different from above)	Date of birth (YYYY-MM-DD)
Self				
Spouse				
Dependant				
Dependant				
Dependant				

Other coverage*

Are you or your dependants 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 Alberta Blue Cross coverage, name of employer)***

Name of member		Date of birth (YYYY-MM-DD)
Policy ID number or Alberta Blue Cross group, section and ID number	**Effective date (YYYY-MM-DD)**	**Cancellation date (YYYY-MM-DD)**

Acknowledgement and consent*

By submitting this Health Services Claim ("*claim*") for processing and payment by Alberta Blue Cross, you consent and agree to the following provisions:

1. The identified services have been received and fully paid for prior to the date of this claim.
2. All information contained in this claim and any supporting documents is complete and true.
3. You authorize us to collect, use, maintain and disclose personal information relevant to this claim for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration, and claim management.
4. You acknowledge and agree that your, or your spouse and dependants', personal information may only be collected from and released to a third party (health care professional, practitioner, or insurer or agent of record) only when needed for a purpose stated above.
5. You confirm you are authorized by your spouse and dependants to consent to this authorization on their behalf.
6. You understand that you can revoke this consent at any time in writing; however, if consent is withheld or revoked coverage may be denied or rescinded.
7. You understand why you have been asked to disclose this information and are aware of the risks and benefits of consenting or refusing to consent.
8. If there is an overpayment, you authorize the recovery of the full amount of the overpayment from any amount payable to you under your benefit plan(s).
9. You confirm for the purposes of verifying or auditing paid claims, you, your spouse and dependents will co-operate fully with Alberta Blue Cross.
10. You understand Alberta Blue Cross is relying on this signed acknowledgement and consent when verifying paid claim(s).
11. You agree that this consent shall be effective on the date noted below and shall be valid for the duration of the time coverage is in force.

Signature of member (required)	Date (YYYY-MM-DD)	**Signature of patient/claimant (or parent/guardian)**

Note: This consent complies with Alberta's Health Information Act and Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act. For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to www.ab.bluecross.ca or email privacy compliance officer at privacy@ab.bluecross.ca.

Please ensure you fill out the **claim section on next page ➔**

Claim information* (*please follow instructions, see reverse*)				
	Date of service (YYYY-MM-DD)	Service description or prescription number	D.I.N. *(prescriptions only)*	Amount claimed
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
			Enter total claim amount	**$** 0

SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO
ALBERTA BLUE CROSS, HEALTH SERVICES, 10009 108 STREET NW, EDMONTON AB T5J 3C5

Receipts *(NOTE: Receipts/invoices with incomplete information will be rejected)*

Attach original paid receipts for each expense claimed and **keep copies for your records, as these receipts will not be returned**. 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. 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 and paid.

Other coverage

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.

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. 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 member 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.

You can view your claim statement online by signing in to our member site at **ab.bluecross.ca**.

EDMONTON	**780-498-8000**
CALGARY	**403-234-9666**
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? Call 1-855-498-7302, contact us through our website or write to Privacy Matters at the address on this form. Visit our website at **ab.bluecross.ca**.

MAIL YOUR CLAIM TO
Alberta Blue Cross Health Services
10009 108 Street NW, Edmonton, AB T5J 3C5