BLUE CROSS® NEXUS NETWORK®

NATIONAL CLAIM FORM

DSU DALHOUSIE STUDENT UNION

MEMBER INFORMATION

ID Number: _____ Policy Number: 0091936000

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.: ( ) _____

Should all correspondence be sent to the above address? ☐ Yes ☐ No

If yes, signature of member is required for validation: _____

If no, please confirm the mailing address for all correspondence: _____

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

DEPENDENT INFORMATION

If the claimant is an over age dependent (as defined in your Plan), please complete the following:

1. Age of Child _____
2. Is he/she unmarried? ☐ Yes ☐ No
3. Is he/she employed full-time? ☐ Yes ☐ No
4. Is he/she attending school, college or university full-time? ☐ Yes ☐ No
5. Is he/she physically or mentally handicapped and dependent on you for support? ☐ Yes ☐ No

OTHER INFORMATION

Was 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 automobile accident? ☐ Yes ☐ No
- Was treatment the result of an injury in the workplace? ☐ Yes ☐ No If Yes, has Worker's Compensation been advised? ☐ Yes ☐ No

CLAIM INFORMATION

	Claimant's Name		Relationship to Member	Date of Birth			Type of Service	Drug Identification Number (DIN)	Date of Service			Amount Paid
	First Name	Last Name	Self, Spouse, Child	day	month	year	E.g. Physiotherapy; diabetic supplies; eye glasses; etc.	(if applicable)	day	month	year	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
											TOTAL CLAIM AMOUNT	

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.

Please see back page for instructions on how to complete this form and our mailing addresses.

IMPORTANT CLAIMING INFORMATION

Please provide all information requested. Incomplete claims may cause delays in processing.

1 Complete all areas on the front of this claim form.

2 Please refer to your Blue Cross card for your Policy and ID numbers.

3 **Keep a copy of your receipts and documents for your records.**

4 All claims must be submitted with itemized statements and original paid-in-full receipts, including the following:

- Claimant's First and Last Name
- Description of item purchased or service rendered
- Date of each purchase or service
- Amount charged for each purchase or service
- Address and telephone number of supplier / provider

5 Claims must be received in our office before the claiming deadline.

6 An Explanation of Benefits statement indicating how this claim was assessed will be sent to the member. If applicable, it will be accompanied by a cheque. The statement can be used for income tax purposes or to claim through another insurance plan. Please retain the Explanation of Benefits as no other statements will be issued.

Photocopies are not acceptable, unless the following situation applies.

Other Coverage:

1 If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.

2 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. (Example: if your birthday is May 1 and your spouse is June 5, your children will claim under your plan first).

3 If you have submitted your original receipt to your other insurance company, please provide the following:

- A photocopy of all invoices and paid-in-full receipts.
- Original statement from the other insurance company showing their payment / denial of the claim.

ADDRESSES*

Alberta
10009 - 108th St NW
Edmonton AB T5J 3C5

British Columbia
PO Box 7000
Vancouver BC V6B 4E1

Manitoba
PO Box 1046
Winnipeg MB R3C 2X7

New Brunswick and Prince Edward Island
PO Box 220
644 Main St
Moncton NB E1C 8L3

Newfoundland and Labrador
Viking Building
136 Crosbie Road, Suite 204
St. John's, NL A1B 3K3

Nova Scotia
PO Box 2200
Halifax NS B3J 3C6
Site: 230 Brownlow Ave, Dartmouth

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

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

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

For all inquiries please call
1-888-873-9200