Clear

BLUE CROSS®

NEXUS NETWORK

Please see back page of this form for addresses.

NATIONAL CLAIM FORM

EMPLOYEE INFORMATION

Identification Number: _____ Policy Number: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Daytime Telephone Number: _____ Employer: _____

COORDINATION OF BENEFIT

Are any benefits or services being claimed available to you or your dependents from any other group insurance, WCB or Government Plan? ❑ Yes ❑ No

If Yes, complete the following:

Name of other Insurer: _____ Cardholder Name: _____

Identification Number: _____ Policy Number: _____

Effective Date: _____ Term Date: _____

Please indicate (✓) type of coverage:

❑ Hospital ❑ Extended Health ❑ Dental ❑ Eye Wear ❑ Drugs ❑ Travel ❑ All

Name of Person(s) insured under other policy	Spouse / Dependent	Date of Birth		
		Day	Month	Year

If student, provide Name of Institution: _____

School Term: _____

OTHER INFORMATION

Is this claim due to an accident? ❑ Yes ❑ No **(If No, move to "Claim Information")**

If Yes, please complete the following:

- Did the accident happen as a result of an automobile accident? ❑ Yes ❑ No
- Did the accident happen while you were at work? ❑ Yes ❑ No

If Yes, has Worker's Compensation been advised? ❑ Yes ❑ No File No.: _____

If Yes to any of the above, please complete the following:

- Date of the accident: _____ Location of the accident: _____

Brief description of the accident: _____

- Has a claim been made to recover damages from the responsible person(s)? ❑ Yes ❑ No

If Yes, please indicate claim number: _____

If No, do you intend to make a claim against the responsible person(s)? ❑ Yes ❑ No

CLAIM INFORMATION

Date of Service / Purchase			Type of Expense	Patient's Name *(Indicate Last Name if different from employee)*		Relationship to employee	Date of Birth			Amount
day	month	year	E.g. Physiotherapy; diabetic supplies; chiropractor; eye wear; prescription drug; etc.	First Name	Last Name	**S** = Spouse **C** = Child **ST** = Student	day	month	year	
									Total	$0.00

EMPLOYEE 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 Blue Cross may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, the cardholder of any contract under which I am a participant**,** and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1-888-873-9200 should I have questions as to the collection, use or disclosure of my personal information.

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

Signature(s) of Patient(s) (Parent/Guardian): _____

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

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws.

ADDRESSES

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

Quebec
550 Sherbrooke West
Suite B9
Montreal QC H3A 3S3

Ontario
PO Box 2000
185 The West Mall Suite 600
Etobicoke ON M9C 5P1

Manitoba
100A Polo Park Centre
PO Box 1046
Winnipeg MB R3C 2X7

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

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

British Columbia
PO Box 7000
Vancouver BC V6B 4E1

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

- *** 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.**