MANITOBA BLUE CROSS®

VISION CARE CLAIM FORM

Please Return Completed Claims To:
CINUP
332 Bannatyne Ave, Suite 500
Winnipeg, MB R3A 0E2
Phone: 1-800-665-1234
Fax: 1-877-786-3889

INSTRUCTIONS:

- THIS FORM IS TO BE USED FOR VISION CARE BENEFITS FOR CORRECTIVE EYEGLASSES/CONTACT LENSES AND EYE EXAMINATIONS.
- BENEFITS PAYABLE SHALL BE DETERMINED BY THE MAXIMUMS AND FREQUENCY LIMITATIONS CONTAINED IN THE COVERAGE AGREEMENT.
- PLEASE COMPLETE **ALL SECTIONS** OF THE CLAIM FORM.
- PLEASE ATTACH AN ITEMIZED RECEIPT OR INVOICE.
- RECEIPTS WILL NOT BE RETURNED - PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.

TO BE COMPLETED BY EMPLOYEE: (PLEASE PRINT CLEARLY)

CERTIFICATE NO.	POLICY	SURNAME OF PATIENT	GIVEN NAME AND INITIAL OF PATIENT	DATE OF BIRTH DAY / MONTH / YEAR
1 0				

EMPLOYEE ADDRESS ______ CITY/TOWN ______ PROVINCE ______

EMPLOYEE NAME: LAST ______ FIRST ______ DATE OF BIRTH DAY / MONTH / YEAR

PRESCRIPTION EYEGLASSES/CONTACT LENSES

PRESCRIBED BY: ❑ OPHTHALMOLOGIST ❑ OPTOMETRIST ❑ PHYSICIAN

DATE OF PURCHASE: ______ / ______ / ______ (DAY / MONTH / YEAR)

AMOUNT BILLED: $ ______ . ____

EYE EXAMINATIONS

EXAM COMPLETED BY: ❑ OPHTHALMOLOGIST ❑ OPTOMETRIST

DATE OF SERVICE: ______ / ______ / ______ (DAY / MONTH / YEAR)

AMOUNT BILLED: $ ______ . ____

LASER EYE SURGERY

DATE OF SERVICE: ______ / ______ / ______ (DAY / MONTH / YEAR)

AMOUNT BILLED: $ ______ . ____

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER VISION CARE COVERAGE? ❑ YES ❑ NO

IF YES, COMPLETE THE FOLLOWING:

CONTRACT HOLDER OF OTHER PLAN ______

BIRTHDATE ______ / ______ / ______ (DAY / MONTH / YEAR)

EMPLOYER ______

EMPLOYER'S INSURANCE CO. ______

POLICY OR CONTRACT NUMBER ______

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER AND COPIES OF THE RECEIPTS.

ASSIGNMENT OF BENEFITS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? ❑ YES ❑ NO

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:

PROVIDER NUMBER ______

NAME ______

ADDRESS ______

______ POSTAL CODE ______

I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT.

EMPLOYEE SIGNATURE ______

IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:

1. AGE OF CHILD ______
2. IS HE/SHE MARRIED? ❑ YES ❑ NO
   IF YES, DATE OF MARRIAGE DD | MM | YY
3. IS HE/SHE EMPLOYED FULL-TIME? ❑ YES ❑ NO
   IF YES, DATE FULL TIME EMPLOYMENT STARTED DD | MM | YY
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? ❑ YES ❑ NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ❑ YES ❑ NO

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE POLICY.

SIGNATURE OF INSURED ______ DATE ______

FOR GLASSES OR CONTACT LENSES, ATTACH PRESCRIPTION OR HAVE SUPPLIER COMPLETE AT PLACE OF PURCHASE:

PRESCRIPTION DETAILS:

	R	L
SPHERE:	R______	L______
CYLINDER:	R______	L______
AXIS:	R______	L______
PRISM 1:	R______	L______
BASE 1:	R______	L______
PRISM 2:	R______	L______
BASE 2:	R______	L______
ADD:	R______	L______

ARE THESE CORRECTIVE LENSES? ❑ YES ❑ NO

IS THIS A PRESCRIPTION CHANGE? ❑ YES ❑ NO

COST:

LENSES	$______
FRAMES	$______
REPAIRS	$______
TINTS/COATINGS	$______
CONTACT LENSES	$______
TOTAL COST	$______

❑ Non-Status ❑ Status If "Status", complete the following:

Total Amount of Claim: $______

Less any reimbursement through NIHB: $______

Balance owing: $______

If the amount paid by NIHB is nil, please indicate why ______

❑ Reached annual limit

❑ Other, please provide details ______

DATE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

SUPPLIER'S SIGNATURE: ______

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AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held by JG Benefits Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my employer, and to manage the organization'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 include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am 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 declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits or consenting or refusing to consent to its disclosure. For additional information regarding JG Benefits Inc.'s group benefits privacy policy I can refer to the Privacy & Terms of Use section of jgbenefits.ca should I have questions as to the collection, use or disclosure of my personal information.