BLUE CROSS®

NEXUS® NETWORK

HEALTH SPENDING ACCOUNT CLAIM FORM

MEMBER INFORMATION

ID Number: _____ Policy Number: _____ Provincial Health Plan Number (only applicable to BC and SK residents): _____

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____

Address: _____

City: _____ Province: _____ 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: _____

OTHER 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: _____ ID Number: _____

Type of policy (✓): ❑ **Individual** ❑ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ❑ Hospital ❑ Travel ❑ Extended Health ❑ Drugs ❑ Vision ❑ Dental ❑ **All**

CLAIM INFORMATION

	Claimant's Name		Relationship to Member	Date of Birth			Type of Service	Date of Service			Amount Paid	Apply unpaid balance to HSA (check for each expense)	
	First Name	Last Name	Self, Spouse, Child	day	month	year	E.g. Physiotherapy; diabetic supplies; eye glasses; etc.	day	month	year		YES	NO
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOTAL CLAIM AMOUNT _____

MEMBER STATEMENT

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 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.**

All medical expenses must be claimed through your provincial and group insurance plans before payment can be made from a Health Spending Account. I confirm that benefits under this plan, any government program or alternate group plan (i.e. spouse's/partner's coverage) have been accessed.

I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. If claiming expenses for an uninsured dependent under your Health/Dental contract, I, the undersinged, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

MEMBER Signature _____ Date _____

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.

ADDRESSES

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

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

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

Manitoba
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.*

INQUIRIES: 1-888-873-9200

*** 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.**