CANADIAN BENEFIT PROVIDERS

CLAIM FORM

CLAIM FORM. Use this form for all pharmaceutical, dental, vision and major medical expenses.

- Attach receipts for each expense claimed and keep photocopies for your records.
- Please print clearly and properly fill out each section to avoid delays.

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (First Name, Last Name)				DATE OF BIRTH (mm/dd/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

Is any other member of your family insured under this plan? Yes ☐ No ☐

For plans with Health Care Spending Account, please check appropriate option below to choose how you want your expenses paid.

☐ **OPTION 1** I want my eligible expenses paid from my Health Plan or Dental Plan.
Do not use my Health Care Spending Account.

☐ **OPTION 2** I want my eligible expenses paid from my Health Plan or Dental Plan first and any unpaid portions of my eligible expenses paid from my Health Care Spending Account.

Note: If no OPTION box has been checked, we will pay claims according to OPTION 2.

PART 2 | COORDINATION OF BENEFITS Fill this section out if you or your spouse are covered under another plan.

Are you, your spouse or dependants covered under any other plan for the expenses being claimed? Yes ☐ No ☐

NAME OF OTHER INSURANCE COMPANY		EFFECTIVE DATE OF PLAN. IF KNOWN	
GROUP #			
NAME OF INSURED (Last Name, First Name)		INSURED'S DATE OF BIRTH (mm/dd/yyyy)	

What Group Benefits coverage does your spouse/common-law spouse have through another plan?

	Single	Family
Health	☐	☐
Dental	☐	☐

HOW TO SUBMIT A CLAIM WHEN YOUR SPOUSE IS COVERED UNDER ANOTHER PLAN:

STEP 1

- For Plan Members: Submit your claim to Canadian Benefit Providers
- For your dependant spouse: Have your spouse submit their claim to their own group benefit plan.
- For your dependant children: Submit their claim to the plan of the parent who has the earlier birth date in the calendar year(the year of birth is not considered). If both parents have the same birth date, submit the claim to the plan of the parent whose given name occurs first in the alphabet.

STEP 2

If a portion of the original claim is not covered by the first plan, submit a claim for the remaining amount to the other group benefit plan. Make sure to include an Explanation of Benefits from the other insurer.

PART 3 | PATIENT INFORMATION

PATIENT NAME	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (mm/dd/yyyy)	DISABLED	FULL-TIME POST-SECONDARY STUDENT
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

PART 4 | CLAIM INFORMATION

Total amount of ALL receipts submitted: $

Prescription Drug Expenses
Attach your receipts to the back of this form. Please note that:

- All receipts must contain the drug identification number (D.I.N.) and the name of the prescription drug.
- You are not required to list this information on the form

Dental Expenses
Attach standard dental claim form from your Dentist. Ensure it shows procedures, tooth number, service date and cost.

Vision Expenses
Attach your official receipt from your service provider. Ensure that it indicates prescription.

Practitioner's/Paramedical Expenses
(e.g. chiropractor, massage, therapist, physiotherapist, etc.)
Attach an itemized statement and/or receipt stating:

- Patient name
- Name of practitioner
- Type of practitioner
- Date of service
- Length of visit
- Charge for treatment
- License and/or registration number

Note: Copies of all original receipts must be attached for all expenses

PART 5 | PLAN MEMBER SIGNATURE

__I certify__ that the information in this form is true and complete to the best of my knowledge. __I authorize__ the release and exchange of information on behalf of my myself, my spouse/common law spouse and/or my dependants solely for the purposes of determining group benefits eligibility and validating claims according to the terms of this Group Insurance Plan. __I recognize__ that my personal information is confidential and will be kept in a private Group Benefits health file and that I have the right to request access to this file, and where appropriate have any inaccurate information corrected. __I am aware__ that if sending a scanned or faxed claim, original receipts must be kept for a period of 1 year and that in the event of an audit, the receipts must be provided within 30 days.

PLAN MEMBER'S SIGNATURE	DATE (mm/dd/yyyy)

Forward this completed form by email, fax or mail to:
Email | claims@cbproviders.ca Fax | 1.844.944.9168
Mail | Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3