

10009 - 108 Street NW, Edmonton, Alberta T5J 3C5

1. SUBSCRIBER INFORMATION * (Refer to your I.D. card)

GROUP NO.	SECTION	SUBSCRIBER'S LAST NAME	FIRST NAME
SUBSCRIBER'S MAILING ADDRESS			PHONE NO. (During business hrs)
CITY		PROVINCE	POSTAL CODE
Has the mailing address changed since the last claim was made under this coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		SubSCRIBER'S CONFIRMATION (please sign)	

2. COMPLETE FOR SUBSCRIBER AND ALL PERSONS BEING CLAIMED FOR ON THIS FORM *

RELATIONSHIP TO SUBSCRIBER	IDENTIFICATION NUMBER	FIRST NAME	LAST NAME (If different from above)	BIRTHDATE		
				YYYY	MM	DD
Self	-					
Spouse	-					
	-					
	-					
	-					

4. CLAIM INFORMATION * (Please follow instructions, see reverse)

	DATE OF SERVICE			SERVICE DESCRIPTION or PRESCRIPTION NUMBER	D.I.N. (Prescriptions only)	AMOUNT CLAIMED
	YYYY	MM	DD			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
ENTER TOTAL CLAIM AMOUNT >						\$ 0.00

PLEASE SEE REVERSE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

**SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO
ALBERTA BLUE CROSS, HEALTH SERVICES,
10009 - 108 STREET NW, EDMONTON AB T5J 3C5**

*All sections must be completed before your claim can be processed. This includes Section 3, *Other Coverage*.

3. OTHER COVERAGE *

Are you or your dependents entitled to receive comparable benefits from any other insurance company, health benefits company or Alberta Blue Cross plan?

No Yes - If yes, complete the following:

NAME OF INSURANCE COMPANY OR OTHER HEALTH BENEFITS COMPANY OR, IF OTHER BLUE CROSS COVERAGE, NAME OF EMPLOYER

NAME OF INSURED / SUBSCRIBER

DATE OF BIRTH
YYYY / MM / DD

POLICY IDENTIFICATION NUMBER OR BLUE CROSS GROUP, SECTION & IDENTIFICATION NUMBER

EFFECTIVE DATE
YYYY / MM / DD

CANCELLATION DATE
YYYY / MM / DD

5. ACKNOWLEDGEMENT AND CONSENT *

By submitting this claim form to Alberta Blue Cross, I/we agree to the provisions of this Acknowledgement and Consent as follows, and:**

- confirm that these services have been received and paid for prior to the date of this claim
- certify that the information contained in this and other documents supporting this claim is true and complete
- understand that the personal information provided herein about me and eligible dependents, as well as other personal information currently held or collected in the future by Alberta Blue Cross, will be used only to determine eligibility for benefits; verify, assess and pay claims; and administer the terms of my benefit plan
- certify that the subscriber is authorized by his/her spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes
- hereby acknowledge and agree that my/our or my dependents' personal information may be exchanged only between Alberta Blue Cross and a licensed physician and/or other health care professional, practitioner, institution or health benefits provider or insurer and only when needed for a purpose stated above
- understand that my/our and my dependents' personal information will be kept confidential and secure.
- understand that I/we may revoke this consent at any time and acknowledge that should I/ we do so, my/our claim may not be considered
- understand why my/our and my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above
- have read and understood this Acknowledgement and Consent
- authorize Alberta Blue Cross to collect, use and disclose my/our and my dependents' personal information as described above
- agree that this consent shall be effective from the date of claim and shall remain in effect as long as the coverage is in force.

Signature of Subscriber _____

Date _____

Signature of Patient/Claimant (or Parent/Guardian) _____

Date _____

*This consent is obtained in accordance with Alberta's Health Information Act and Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.
**I/we - refers to the one or more individuals signing and/or submitting this form.