BLUE CROSS®

NEXUS® NETWORK

Please see back page of this form for addresses.

NATIONAL CLAIM FORM

MEMBER INFORMATION

Identification Number: _____ Policy Number: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Daytime Telephone Number: _____ Employer: _____

COORDINATION OF BENEFITS

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

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

MEMBER 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 containted 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 my Blue Cross plan may be collected, used, or disclosed to administer and manage the terms of my plan or the group 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.

Signature _____ Date _____
(If under 18 years of age, the signature of the member is required)

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.
*applicable in Atlantic Canada

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

For all inquiries please call,
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.**

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