MEDAVIE BLUE CROSS™

VISION CLAIM FORM

PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS

SUBSCRIBER INFORMATION - To be completed by subscriber or patient

Subscriber Name _____

Address _____ City _____ Province _____ Postal Code _____

Telephone No. _____ Identification No. _____ Policy No. _____

PATIENT INFORMATION - To be completed by subscriber or patient

Patient Name _____ Date of Birth _____ If dependent is over the age 21: ❑ Special Dependent ❑ Full-Time Student

Identification No. _____ If Student, School Name _____

Address _____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent Telephone No. _____

COORDINATION OF BENEFITS INFORMATION

Do you or your dependent(s) have other coverage provided under any other plan? ❑ Yes ❑ No

If Yes, complete the following: Name of other insurer: _____

Name of Person(s) insured under other policy	Date of Birth DD	MM	YYYY

Effective Date of Coverage _____

Identification No. _____

Policy No. _____

Type of coverage:

❑ Hospital ❑ Vision ❑ EHB

❑ Drugs ❑ Dental ❑ All

I hereby authorize any and all vision care providers to release to Medavie Blue Cross any information that relates to or supports claims submitted on my behalf, 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 Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me*, and to manage Blue Cross'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 third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an 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, in some instances doing so may prevent Blue Cross 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 Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature _____ Date _____

(If under 18 years of age the signature of the subscriber is required.)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

*not applicable in Ontario or Quebec

VISION CLAIM INFORMATION - To be completed by the Provider

Provider Name _____

Address _____ City _____ Province _____ Postal Code _____

Provider No. _____ Telephone No. _____ Patient Name _____

Is this a new patient? ❑ Yes ❑ No

Are lenses required due to a medical condition/disease? (To be completed by prescriber) ❑ Yes ❑ No _____

If Yes, state condition/disease _____

Benefit Description	Date of Service DD/MM/YY *(Date Goods Paid-in-Full)*	Charge *(Must be broken down by benefit description)*
Eye Examination		
Frame		
Right Lens		
Left Lens		
Right Contact Lens		
Left Contact Lens		
Tinting		
UV Coating		
Anti-Reflection Coating		
Plano Sunglasses		
Other *		
	TOTAL	

Details of this Prescription

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					

ADD		
	R	
	L	

Bifocal Type ❑ Round ❑ ST

If changed, details of last Prescription (This information is not required if this is a new patient)

	SPHERE	CYLND.	AXIS	PRISM	BASE
RIGHT					
LEFT					

ADD		
	R	
	L	

Bifocal Type ❑ Round ❑ ST

* Description of Other: _____

Type of Right Lens: ❑ Single ❑ Bifocal ❑ Multifocal ❑ Progressive ❑ Spherical ❑ Compound ❑ Hi Index ❑ Polycarbonate ❑ Aspheric ❑ Slaboff

Type of Left Lens: ❑ Single ❑ Bifocal ❑ Multifocal ❑ Progressive ❑ Spherical ❑ Compound ❑ Hi Index ❑ Polycarbonate ❑ Aspheric ❑ Slaboff

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: _____ Date: _____

MEDAVIE BLUE CROSS ADDRESSES

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