

P R O V I D E R	PROVIDER NO.	NAME	S U B S C R I B E R	CONTRACT NUMBER		GROUP NUMBER
	ADDRESS			SURNAME		FIRST NAME
	CITY/PROVINCE	POSTAL CODE		ADDRESS		BIRTH DATE DD MM YY
P A T I E N T	WAS SERVICE THE RESULT OF: A MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER ACCIDENT TYPE? <input type="checkbox"/> YES <input type="checkbox"/> NO		P A T I E N T	CITY, PROVINCE		POSTAL CODE
	ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING POLICY HOLDER OF OTHER PLAN _____ BIRTH DATE _____ / _____ / _____ DAY MONTH YEAR EMPLOYER _____ EMPLOYER'S INSURANCE COMPANY _____ POLICY OR CONTRACT NUMBER _____ IF BLUE CROSS IS 2nd INSURER ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM 1st INSURER.			HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO PATIENT INFORMATION MUST BE GIVEN PATIENT'S NAME _____ BIRTH DATE _____ Day Month Year RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> 1 SELF <input type="checkbox"/> 2 SPOUSE <input type="checkbox"/> 3 DEPENDENT PHONE HOME _____ OFFICE _____ IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, COMPLETE THE FOLLOWING: 1. AGE OF CHILD _____ 2. IS HE/SHE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. IS HE/SHE EMPLOYED FULL TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO 4. IS HE/SHE IN FULL TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
S U B S C R I B E R			P A T I E N T / S U B S C R I B E R			

ASSIGNMENT OF BENEFITS

IS PAYMENT TO BE MADE TO THE PROVIDER OF THE SERVICE? ☐ YES ☐ NO

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PROVIDER FOR THE ENTIRE COST OF THE SERVICE.

SUBSCRIBER'S SIGNATURE: _____

CLAIM DETAILS

(TO BE COMPLETED BY THE PROVIDER OF SERVICE OR ATTACH AN ITEMIZED RECEIPT OR INVOICE)

ACCOUNT / CALL NO.	DATE OF SERVICE Day Month Year	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	TRANSPORTED FROM:	PERSONAL CARE HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	TRANSPORTED TO:	PERSONAL CARE HOME <input type="checkbox"/> YES <input type="checkbox"/> NO
--------------------	-----------------------------------	---	-------------------	--	-----------------	--

IS THIS PATIENT: ☐ RESIDENT ☐ NON-RESIDENT

IS THIS A WALKING PATIENT: ☐ YES ☐ NO

ARE THE SERVICES: ☐ EMERGENCY ☐ NON-EMERGENCY

IF NON-EMERGENCY PLEASE STATE THE NAME OF THE PHYSICIAN WHO AUTHORIZED THE TRIP: _____

DESCRIPTION	AMOUNT BILLED	BLUECROSS PAYS
BASE RATE		
KM CHARGE X NO. OF KM		
FLAT RATE TO: FROM:		
OTHER:		
TOTAL CHARGES	\$	\$

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

PROVIDER'S SIGNATURE: _____ DATE: _____

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba 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 develop and recommend suitable products and services to me, and to manage the Company'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 include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group 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, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or at www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.