MEDAVIE BLUE CROSS™

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
INQUIRIES: 1-800-667-4511

PROGRAMME DES ÉLÈVES INTERNATIONAUX NOUVEAU-BRUNSWICK

NEW BRUNSWICK FRENCH INTERNATIONAL STUDENT PROGRAM CLAIM FORM

MEMBER INFORMATION (Please provide address of residence in New Brunswick)

ID Number: _____ Policy No. 11025 School: _____
Student: Last Name: _____ First Name: _____
Address: _____ City: _____ Prov: _____ Postal Code: _____
Telephone: (_____) _____ E-mail: _____
Host Family: Last Name: _____ First Name: _____

OTHER INFORMATION

Is this claim due to an accident? ❑ **Yes** ❑ **No** **If No, skip to next Section**
If Yes, complete the following:
Did the accident happen as a result of an automobile accident? ❑ Yes ❑ No
If yes, complete the following:
Date of accident: _____ Location of accident: _____
Brief description of accident: _____
Are the injuries suffered in whole or in part due to the fault of another party? ❑ Yes ❑ No
If yes, provide the following:
Has a claim been made to recover damages from the responsible person(s)? ❑ Yes ❑ No If No, do you intend to make a claim against the responsible person(s)? ❑ Yes ❑ No
Please provide the name, address and telephone number of your lawyer: _____

CLAIM INFORMATION - To be completed by provider

Provider Name: _____ Provider No. _____ Telephone: _____
Address: _____ City: _____ Prov: _____ Postal Code: _____
Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

Date of Service DD	MM	YYYY	Type of Service	Name of Prescriber / Recommender	Provincial Service Code (if applicable)	Charges
					TOTAL CHARGES	

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 pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: _____ Date: _____

ASSIGNMENT OF PAYMENT

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to their office. I understand that the fees listed on this claim may not be covered or may exceed my plan Benefits. I understand that I am financially responsible to the provider for the entire treatment.

Signature of Patient / Host / Guardian: X _____

PATIENT (HOST/GUARDIAN) STATEMENT

I hereby authorize the health care provider identified above to release to Medavie Blue Cross any medical information about me and my dependents which relates to claims submitted by us, or on our behalf, to Medavie Blue Cross. I hereby certify that the services listed have been rendered and that any information relating to these services, and supporting documentation of this information, may be obtained by Medavie Blue Cross for verification purposes.

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 of Patient / Host / Guardian: X _____ Date: _____
(If under 18 years of age the signature of the Host / Guardian 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**.

Please ensure all areas are complete. Please ensure all original supporting receipt/invoices are attached, if applicable.
A direct deposit form must be submitted for reimbursement claims.