# MEDAVIE BLUE CROSS™

# VISION CLAIM FORM

**PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS**

## MEMBER INFORMATION

ID Number: ______ Policy Number: ______ Date of Birth (DD/MM/YYYY) ______

Last Name: ______ First Name: ______

Address: ______ City: ______ Province: ______ Postal Code: ______

Home Telephone Number: ______ Work Telephone Number: ______

Has your mailing address changed since your last claim? ❑ Yes ❑ No If yes, signature of member is required for validation: ______

## OTHER COVERAGE

Do you or any of your dependents have other coverage under any other plan?

❑ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): ______

❑ **Yes** **Complete the following:** Name of other Insurer: ______

Member Name: ______ ID Number: ______

**Type of policy (✓):** ❑ **Individual** ❑ **Group** Effective Date: ______ Policy Number: ______

**Please indicate type of coverage (✓):** ❑ Hospital ❑ Travel ❑ Extended Health ❑ Drugs ❑ Vision ❑ Dental ❑ **All**

## MEMBER STATEMENT

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 member 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 **X** ______ 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 privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

## VISION CLAIM INFORMATION - To be completed by the Provider

Provider Name: ______ Provider No.: ______ Telephone: ______

Address: ______ City: ______ Province: ______ Postal Code: ______

Patient Name: ______ Date of Birth (DD/MM/YYYY): ______

Is this a new patient? ❑ Yes ❑ No Are lenses required due to a medical condition/disease? ❑ Yes ❑ No

If Yes, state condition/disease: ______

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

* Description of Other: ______

**Details of this prescription**

| | SPHERE | CYLND. | AXIS | PRISM | BASE |
|---|---|---|---|---|---|
| RIGHT | | | | | |
| LEFT | | | | | |
| ADD R | | | | | |
| ADD 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 | | | | | |
| ADD L | | | | | |

Bifocal Type ❑ Round ❑ ST

**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: **X** ______ Date: ______

## MEDAVIE BLUE CROSS ADDRESSES

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Kenmount Business Centre
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