MEDAVIE BLUE CROSS™

RCMP Member Health Benefits Claim Form

Protected (when completed)

***Please ensure all areas are complete. Incomplete information may delay processing.**
***Please attach all original paid-in-full receipts.**
***Prescription drug receipts must indicate name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.**
***All receipts must indicate name of supplier/provider, item/service rendered and provider telephone number.**

Note: Reimbursement will be in accordance with the RCMP Benefit Grid available at www.medavie.bluecross.ca/Myinfo.

Member Information

Health Identification Number _____ Date of Birth _____ DD MM YYYY

Last Name: _____ First Name _____

Work Address _____

City _____ Province _____ Postal Code _____

Work Telephone Number _____

Other Information

Was this treatment for Hospital/Medical Services outside of the Province/Territory? ☐ Yes ☐ No
If yes, were the Hospital/Medical Services outside of the Province/Territory required while on duty? ☐ Yes ☐ No
Was emergency treatment provided outside of Canada? ☐ Yes ☐ No
Was the treatment the result of a work-related injury/illness? ☐ Yes ☐ No
Is this a Supplemental Health Care benefit? ☐ Yes ☐ No
If yes, is authorization required? ☐ Yes ☐ No
If yes, provide authorization number. _____
Is this an Occupational Health Care benefit*? ☐ Yes ☐ No
If yes, provide authorization number. _____
* Please contact your divisional OHSS office if you require an authorization for OHC benefits.
Has a third-party insurance agreed to pay for treatment? ☐ Yes ☐ No

Liaison Officers ONLY

Was non-emergency (BHC/SHC) treatment provided outside of Canada? ☐ Yes ☐ No

Claim Information

Date of Service DD / MM / YYYY	Type of Service I.e.: Podiatry, diabetic supplies, eyeglasses, etc.	Quantity	Amount Paid
		TOTAL CLAIM AMOUNT	

Certification

I certify that I have not claimed and will not claim these expenses under any other insurance and that all information contained herein is correct.

I hereby authorize any health care provider 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 may be collected, used or disclosed to administer RCMP Supplemental and Occupational Health Care Benefits for which I am an eligible member.

I understand that my personal information is protected from unauthorized disclosure by the *Privacy Act*.

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 Medavie Blue Cross from providing me with the requested claim reimbursement. 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 _____

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca/Myinfo or call 1-888-261-4033.

Mail to:

Medavie Blue Cross, PO Box 6700, Moncton, NB E1C 0T8

FAP-035E 01/17

Instructions

Member Information

- Your Health Identification Number is indicated on your Medavie Blue Cross card.
- Please indicate your work address and telephone number **ONLY**.

Other Information - Please provide all required information.

- A Supplemental Health Care (SHC) benefit is a product or service required on an as-needed basis not normally considered an insured benefit under provincial/territorial health care plans. It includes prescription drugs, dental services, vision care, physiotherapy, etc. An authorization may be required prior to obtaining the product or service. You can verify if an authorization or referral is required on your Member Portal at: www.medavie.bluecross.ca/MyInfo.
- An Occupational Health Care (OHC) benefit is a product or service that is required when an eligible member becomes unfit-for-duty due to an injury or illness, and requires treatment beyond the limits provided through RCMP Health Benefits Programs to return the member to fit-for-duty status or to maintain a fit-for-duty status. An authorization is required for **all** products or services. Please contact your divisional Occupational Health and Safety Services (OHSS) office for an authorization of OHC benefits.
- To expedite the adjudication of the claim:
  - If you have received an authorization number from the divisional OHSS for SHC or OHC benefits, please indicate the authorization number on the form when submitting your claim.
  - If a referral is required for either a SHC or OHC product or service, please provide the original when submitting your claim and provide a **valid copy** with subsequent claims.
  - Please verify if the product or service you are claiming has a maximum reimbursement amount. Your claim will be adjudicated according to maximum amount defined on the RCMP Benefits Grid. You can view the RCMP Benefits Grid on your Member Portal at: www.medavie.bluecross.ca/MyInfo.
- **Third-party insurance** means the purchase of insurance by the insured from an insurance company against another party's claims. (ex.: Insurance companies, Health and Automobile)
- For Liaison Officer (LO) **ONLY**: Indicate if the non-emergency product or service was provided outside Canada or country of posting. Non-emergency product or service includes Basic Health Care (BHC) and/or Supplemental Health Care (SHC).

Claim Information

- Please enter the date of service and description for all product(s) or service(s) and include the total amount being claimed.
- Attach original paid receipts for each expense claimed and **keep copies for your records, as these receipts will not be returned**.

All original receipts must indicate the following information:

- first and last name of member receiving the product or service;
- date(s) product or service was obtained;
- description of product or services purchased;
- provider's name, address, and licensing information (if required); and
- amount paid.

Certification

- Your signature is mandatory. Any forms that are not signed will be returned to the member's work address provided on the claim form.
- Please ensure that you include all invoices/referrals with the claim form.