MEDAVIE BLUE CROSS™

RCMP Member Health Benefits Claim Form

Protected "B" (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 _____ D-J M-M Y-A

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 D - J M - M Y - A	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 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 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