

PROVIDER	PROVIDER NUMBER	NAME	SUBSCRIBER		CONTRACT NUMBER	GROUP NUMBER		
	ADDRESS			SURNAME		FIRST NAME		
	CITY/PROVINCE			POSTAL CODE		ADDRESS		
PATIENT	WAS SERVICE THE RESULT OF:		PATIENT	CITY/PROVINCE		POSTAL CODE		
	A MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	AN INJURY AT THE WORKPLACE? <input type="checkbox"/> YES <input type="checkbox"/> NO			SUBSCRIBER/PATIENT		PATIENT INFORMATION MUST BE GIVEN		PATIENT'S NAME
ANOTHER ACCIDENT TYPE? <input type="checkbox"/> YES <input type="checkbox"/> NO		RELATIONSHIP TO SUBSCRIBER				BIRTHDATE		DAY MONTH YEAR
SUBSCRIBER	PLEASE GIVE DETAILS _____		HOME		OFFICE			
	ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?		PHONE		IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:			
	<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING		EMPLOYER _____		1. AGE OF CHILD _____			
	IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER.		EMPLOYER'S INSURANCE COMPANY _____		2. IS HE/SHE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
POLICYHOLDER OF OTHER PLAN _____		POLICY OR CONTRACT NUMBER _____		3. IS HE/SHE EMPLOYED FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO				
BIRTHDATE ____ / ____ / ____				4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DAY MONTH YEAR				5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO				

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 SERVICE.

SUBSCRIBER'S SIGNATURE: _____

CLAIM DETAILS

ACCOUNT NUMBER	ADMISSION DATE	HAS THIS PATIENT BEEN DESIGNATED AS A PANELLED PATIENT?	DATE OF PANELLING _____	WAS THIS PATIENT IN CHRONIC CARE?
	DAY MONTH YEAR	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

DESCRIPTION	AMOUNT BILLED
SEMI-PRIVATE ACCOMMODATION: FROM: DAY MONTH YEAR TO: DAY MONTH YEAR DAILY RATE: NUMBER OF DAYS	
PRIVATE ACCOMMODATION: FROM: DAY MONTH YEAR TO: DAY MONTH YEAR DAILY RATE: NUMBER OF DAYS	
REFUND ALLOWANCE: DAYS IN WARD FROM: DAY MONTH YEAR TO: DAY MONTH YEAR DAILY RATE: NUMBER OF DAYS	
WAS A SEMI-PRIVATE ROOM REQUESTED UPON ADMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO WAS A SEMI-PRIVATE ROOM AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IN PATIENT ALLOWANCE: FROM: DAY MONTH YEAR TO: DAY MONTH YEAR DAILY RATE: NUMBER OF DAYS	
DIAGNOSIS:	
HOSTEL ACCOMMODATION: FROM: DAY MONTH YEAR TO: DAY MONTH YEAR DAILY RATE: NUMBER OF DAYS	
TOTAL CHARGES	

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

PROVIDER'S SIGNATURE: _____ DATE: _____

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7 PHONE 775-0151 OR TOLL FREE WITHIN MANITOBA 1-800-USE-BLUE (1-800-873-2583)

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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 toll free at 1-800-873-2583 or 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.