MANITOBA BLUE CROSS

HOSPITAL CLAIM FORM

PROVIDER

PROVIDER NUMBER | NAME

ADDRESS

CITY/PROVINCE | POSTAL CODE

PATIENT

WAS SERVICE THE RESULT OF:

A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

AN INJURY AT THE WORKPLACE? ☐ YES ☐ NO

ANOTHER ACCIDENT TYPE? ☐ YES ☐ NO

PLEASE GIVE DETAILS_____

SUBSCRIBER

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER.

POLICYHOLDER OF OTHER PLAN _____

BIRTHDATE _____/_____/_____
DAY MONTH YEAR

EMPLOYER _____

EMPLOYER'S INSURANCE COMPANY _____

POLICY OR CONTRACT NUMBER _____

SUBSCRIBER

CONTRACT NUMBER | GROUP NUMBER

SURNAME | FIRST NAME

ADDRESS | BIRTHDATE DAY MONTH YEAR

CITY/PROVINCE | POSTAL CODE

HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? ☐ YES ☐ NO

PATIENT

PATIENT INFORMATION MUST BE GIVEN

PATIENT'S NAME | BIRTHDATE DAY MONTH YEAR

RELATIONSHIP TO SUBSCRIBER ☐ 1 SELF ☐ 2 SPOUSE ☐ 3 DEPENDENT

PHONE

HOME OFFICE

SUBSCRIBER/PATIENT

IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

1. AGE OF CHILD _____
2. IS HE/SHE MARRIED? ☐ YES ☐ NO
3. IS HE/SHE EMPLOYED FULL-TIME? ☐ YES ☐ NO
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? ☐ YES ☐ NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ☐ YES ☐ 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 DAY MONTH YEAR | HAS THIS PATIENT BEEN DESIGNATED AS A PANELLED PATIENT? ☐ YES ☐ NO DATE OF PANELLING _____ | WAS THIS PATIENT IN CHRONIC CARE? ☐ YES ☐ 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	NUMBER OF DAYS	
WAS A SEMI-PRIVATE ROOM REQUESTED UPON ADMISSION? ☐ YES ☐ NO	WAS A SEMI-PRIVATE ROOM AVAILABLE? ☐ YES ☐ 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	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)

MBC 1001_JUNE 200

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.