MANITOBA BLUE CROSS™

GOVERNMENT OF MANITOBA EMPLOYEE VISION PLAN

VISION CARE CLAIM FORM

INSTRUCTIONS:

- THIS FORM IS TO BE USED FOR VISION CARE BENEFITS FOR CORRECTIVE EYEGLASSES/CONTACT LENSES AND EYE EXAMINATIONS.
- BENEFITS PAYABLE SHALL BE DETERMINED BY THE MAXIMUMS AND FREQUENCY LIMITATIONS CONTAINED IN THE COVERAGE AGREEMENT.
- PLEASE COMPLETE ALL **SECTIONS** OF THE CLAIM FORM.
- PLEASE ATTACH AN ITEMIZED RECEIPT OR INVOICE.
- EFFECTIVE JANUARY 1, 2000, RECEIPTS WILL NO LONGER BE RETURNED
- PATIENTS 65 YEARS OF AGE AND OLDER, PLEASE ATTACH MANITOBA HEALTH CHEQUE STUB.
- SEND COMPLETED CLAIM FORM, RECEIPTS, ETC. TO:

MANITOBA BLUE CROSS
P.O. BOX 1046
WINNIPEG, MB R3C 2X7

TO BE COMPLETED BY SUBSCRIBER: (PLEASE PRINT CLEARLY)

BLUE CROSS CONTRACT NO.	GROUP	SURNAME OF PATIENT	GIVEN NAME AND INITIAL OF PATIENT	DATE OF BIRTH DAY / MONTH / YEAR

SUBSCRIBER ADDRESS	CITY/TOWN	PROVINCE

PRESCRIPTION EYEGLASSES/CONTACT LENSES

PRESCRIBED BY: ❑ OPHTHALMOLOGIST ❑ OPTOMETRIST ❑ PHYSICIAN

DATE OF PURCHASE: ______/______/______ (DAY / MONTH / YEAR)

AMOUNT BILLED: $ ________ . ____

EYE EXAMINATIONS

EXAM COMPLETED BY: ❑ OPHTHALMOLOGIST ❑ OPTOMETRIST

DATE OF SERVICE: ______/______/______ (DAY / MONTH / YEAR)

AMOUNT BILLED: $ ________ . ____

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER VISION CARE COVERAGE? ❑ YES ❑ NO

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM 1ST INSURER.

IF YES, COMPLETE THE FOLLOWING:

CONTRACT HOLDER OF OTHER PLAN ________

BIRTHDATE ______/______/______ (DAY / MONTH / YEAR)

EMPLOYER ________

EMPLOYER'S INSURANCE CO. ________

POLICY OR CONTRACT NUMBER ________

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING:

NAME OF SUPPLIER: ________

ADDRESS: ________

____

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 ABOVE PROVIDER FOR THE COST OF TREATMENT.

SUBSCRIBER'S SIGNATURE ________
(PLEASE SIGN HERE)

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

1. AGE OF CHILD ________
2. IS HE/SHE UNMARRIED? ❑ YES ❑ NO
3. IS HE/SHE EMPLOYED FULL-TIME? ❑ YES ❑ NO

IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? ❑ YES ❑ NO

IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ❑ 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 AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE CONTRACT.

SIGNATURE OF INSURED ________ DATE ________

TO BE COMPLETED BY SUPPLIER AT PLACE OF PURCHASE:

PRESCRIPTION DETAILS:

	R	L
SPHERE:		
CYLINDER:		
AXIS:		
PRISM 1:		
BASE 1:		
PRISM 2:		
BASE 2:		
ADD:		

ARE THESE CORRECTIVE LENSES? ❑ YES ❑ NO

IS THIS A PRESCRIPTION CHANGE? ❑ YES ❑ NO

COST:

LENSES	$
FRAMES	$
REPAIRS	$
TINTS/COATINGS	$
CONTACT LENSES	$
TOTAL COST	$

DATE

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

SUPPLIER'S SIGNATURE: ________

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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 at 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.