MANITOBA BLUE CROSS®

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.
- RECEIPTS WILL NOT BE RETURNED – PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.
- PEASE RETAIN OUR EXPLANATION OF BENEFITS FOR COORDINATION OF BENEFITS OR INCOME TAX PURPOSES.
- 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 NUMBER	GROUP NUMBER	SURNAME OF PATIENT	GIVEN NAME AND INITIAL OF PATIENT	BIRTHDATE DAY / MONTH / YEAR

SUBSCRIBER ADDRESS | CITY/TOWN | PROVINCE | POSTAL CODE | HAS YOUR ADDRESS CHANGED IN THE PAST YEAR ☐ YES ☐ NO

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 INSURANCE OR PLAN FOR THE EXPENSE CLAIMED? ☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

POLICY HOLDER OF OTHER PLAN

BIRTHDATE ___ / ___ / ___ (DAY / MONTH / YEAR)

EMPLOYER

EMPLOYER'S INSURANCE CO.

POLICY OR CONTRACT NUMBER

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

ASSIGNMENT OF BENEFITS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?

☐ YES ☐ NO

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:

PROVIDER NUMBER

NAME

ADDRESS

POSTAL CODE

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 _____

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

1. AGE OF CHILD
2. IS HE/SHE MARRIED? ☐ YES ☐ NO
   IF YES, DATE OF MARRIAGE DD MM YY
3. IS HE/SHE EMPLOYED FULL-TIME? ☐ YES ☐ NO
   IF YES, DATE FULL TIME EMPLOYMENT STARTED DD MM YY
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

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

FOR GLASSES OR CONTACT LENSES, ATTACH PRESCRIPTION OR HAVE SUPPLIER COMPLETE AT PLACE OF PURCHASE

PRESCRIPTION DETAILS:

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

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: _____

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7, PHONE 775-0151 OR TOLL FREE WITHIN MANITOBA 1-800-USE-BLUE (1-800-873-2583) FAX 772-1231

MBC 1050-20M-05/2009

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.