## **VISION CARE CLAIM FORM**

## **INSTRUCTIONS:**

MANITOBA

- THIS FORM IS TO BE USED FOR VISION CARE BENEFITS FOR COR-RECTIVE 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.

BLUE CROSS®

- 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.
- PLEASE RETAIN OUR EXPLANATION OF BENEFITS FOR COORDINA-TION 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: (PLEAS	SE 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 IN YES IN NO
PRESCRIPTION EYEGLASSES/CONTACT LENSES	ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY
PRESCRIBED BY: 🖵 OPHTHALMOLOGIST 📮 OPTOMETRIST 📮 PHYSICIAI	
DATE OF PURCHASE:///	IF YES, COMPLETE THE FOLLOWING:     POLICY HOLDER OF OTHER PLAN
DAY MONTH YEAR AMOUNT BILLED: \$	
EYE EXAMINATIONS	EMPLOYER
EXAM COMPLETED BY: 📮 OPHTHALMOLOGIST 📮 OPTOMETRIST	EMPLOYER'S INSURANCE CO.
DATE OF SERVICE: / /	POLICY OR CONTRACT NUMBER
DAY MONTH YEAR AMOUNT BILLED: \$	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	IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE
IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?	COMPLETE THE FOLLOWING: 1. AGE OF CHILD
YES  NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:	2. IS HE/SHE MARRIED?
PROVIDER NUMBER	IF YES, DATE OF MARRIAGE
NAME	3. IS HE/SHE EMPLOYED FULL-TIME?
ADDRESS	IF YES. DATE FULL TIME EMPLOYMENT STARTED DD MM YY
POSTAL CODE	<ul> <li>4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL</li> </ul>
I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR M	
EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY F SPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT.	5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED
SUBSCRIBER'S SIGNATURE	AND DEPENDENT ON YOU FOR SUPPORT?
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:	ARE THESE CORRECTIVE LENSES?  YES  NO
SPHERE: R L	IS THIS A PRESCRIPTION CHANGE?
CYLINDER: R L	COST:
AXIS: R L	LENSES \$
PRISM 1: R L	FRAMES \$
BASE 1: R L	REPAIRS \$
PRISM 2: R L	TINTS/COATINGS \$
BASE 2: R L	CONTACT LENSES \$
ADD: R L	TOTAL COST \$
DATE I HEREBY CERTIFY TH THE PATIENT NAMED.	AT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO
SUPPLIER'S SIGNATU	RE:
A     Benistand trademarks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross Plans, used under license by Manitoba Blue Cross	

P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7, PHONE 204-775-0151 OR TOLL FREE WITHIN MANITOBA 1-800-USE-BLUE (1-800-873-2583) FAX 204-772-1231 MBC 1050-20M-03/2012

## **AUTHORIZATION AND CONSENT**

I understand that the personal information provided herein as well as any other personal information currently held by studentcare.net/works and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my Association, and to manage the organization'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 the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am 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 declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits or consenting or refusing to consent to its disclosure.

For additional information regarding studentcare.net/works privacy policy I can contact studentcare.net/works at www.ihaveaplan.ca/privacy should I have questions as to the collection, use or disclosure of my personal information. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1-800-873-2583 or at www.mb.bluecross.ca.