



HEALTH SPENDING ACCOUNT CLAIM FORM

MEMBER INFORMATION											
ID Number:	Policy Number:	Provincial Health Plan Number(only applicable to BC and SK residents):									
Last Name:	First Name:			Date of Birth (DD/MM/YYYY):							
Address:											
City: Postal Code:											
Home Telephone Number: Work Telephone Number:											
Has your mailing address changed since your last claim? Yes No If yes, signature of member is required for validation:											
OTHER COVERAGE											
Do you or any dependents have coverage under any other plan? No If applicable, please provide the Termination Date (dd/mm/yyyy):											
Type of policy (🗸): 🗆 Individual 🗅 Group Effective Date: Policy Number:											
Please indicate type of covera	nge (√): □ Hospital □	Travel 🗅 Exte	ended He	Health 🗅 Drugs 🗅 Vision							
CLAIM INFORMATION											
Claimant's Name	Relationship to Member			Type of Service E.g. Physiotherapy;	Dat	Date of Service		Amount Paid	Apply unpaid balance to HSA (check for each expense)		
First Name Last N		day month	year	diabetic supplies; eye glasses; etc.	day	month	year		YES	NO	
1											
2											
3											
4											
5											
6											
7											
8											
9											
10	TOTAL CLAIM AMOUNT										
MEMBER STATEMENT											
I understand that the personal informatic to administer and manage the terms of in the purposes listed above, limited person another Blue Cross organization, a licendependent or another third party. I understand that my personal informatic plan from providing me with the requested consenting or refusing to consent to it.	ny plan of which I am an eligible in all information may be collected is sed physician, health care profes on will be kept confidential and seed coverage or benefits. I unders	member or depende from and /or release sional or institution, cure. I understand stand why my perso	ent, to recored to a third life and he that I may r nal informat	mmend suitable product party. This third party alth insurer, government revoke my consent at a tion is needed and I am	ets and ser may inclu- nt and regulary any time, he n aware of	vices to mode ulatory au owever, in the risks	ne, and to thorities, the some instand benefit	manage my Blue Cro ne member of any pla tances doing so may its	ess plan's bus an under whi	siness. For	
All medical expenses must be claimed the government program or alternate group I understand that should any tax consunder your Health/Dental contract, I, the	nrough your provincial and group plan (i.e. spouse's/partner's cove sequences arise from reimburs	insurance plans be rage) have been ac ement of these ex	fore payme ccessed. penses, I a	nt can be made from a	Health Sp	ending Ao	ecount. I c	confirm that benefits using expenses for an using expense for an using expenses for an using expenses for an usual expenses for an usual expenses for an usual expenses for an usual expenses for a usu	uninsured de		
MEMBER Signature Date This consent complies with federal and provincial privacy laws. For additional information regarding your Blue Cross plan's privacy policies, call 1-888-873-9200.											
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ADDRESSES

Atlantic Canada Saskatchewan **British Columbia** Quebec Ontario Manitoba Alberta PO Box 220 550 Sherbrooke West PO Box 2000 PO Box 1046 PO Box 4030 10009 - 108th St NW PO Box 7000 644 Main St PO Box 3300, 185 The West Mall Winnipeg MB R3C 2X7 516 2nd Avenue N Edmonton AB T5J 3C5 Vancouver BC V6B 4E1 Saskatoon SK S7K 3T2

Moncton NB E1C 8L3 Postal Station B Suite 1200 Montreal QC H3B 4Y5 Etobicoke ON M9C 5P1

- INQUIRIES: 1-888-873-9200 * Each plan is an independent licensee of the Canadian Association of Blue Cross Plans.
- Please ensure all areas are complete. Incomplete information may delay processing.
 Please attach all original paid-in-full receipts or an EOB from the primary carrier and photocopies of receipts.
- * Prescription drug receipts must indicate: name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.
- * Original receipts will not be returned.
- * All receipts should indicate: name of supplier/provider, item/service rendered, provider telephone number.