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

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