Extended Health Claim Form

For Prescription Drugs, Vision Care and Supplementary Health

ATTACH THE ORIGINAL RECEIPTS FOR ALL EXPENSES. Receipts will not be returned to you. Copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans. Your Explanation of Benefits will be available once your claim is processed.

Member Information

Last Name	First Name	Certificate Number	
Mailing Address	**City**	**Province**	**Postal Code**
Phone Number	**Cell Phone**	**Email Address**	**Date of Birth**
			Month Day Year

Patient Information

Is the patient(s) entitled to benefits under any other plan?	☐ Yes ☐ No	***Note:*** *Dependant children must first be claimed under the parent with the earlier date of birth.*

If yes, please retain photocopies of all receipts submitted in this claim for submission to secondary carrier. If Ellement Consulting Group is the first payer, please attach all receipts and the co-insurance statement.

If yes, please indicate the date of birth of the insured: Month Day Year

Claim Details

Patient Name (Last, First)	Relationship to Member	Date of Birth	Total # of Receipts	Total Charges
	☐ Member ☐ Spouse ☐ Child	Month Day Year		
	☐ Member ☐ Spouse ☐ Child	Month Day Year		
	☐ Member ☐ Spouse ☐ Child	Month Day Year		

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the provider.
Name of Service Provider

_____
Member Signature

Authorization and Consent

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement Consulting Group to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct, and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/ or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the provider for the entire amount. I agree that a photocopy or electronic copy of this form is as valid as the original.

_____
Member Signature ***(must be in ink)***

Month Day Year
_____
Date Signed

Plan Administrator
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