Ironworkers Health & Welfare Trust Fund of Western Canada
Prescription Drug Claim Form

Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

Member Information Section

Group Number	Certificate Number	Gender			Language Preference	
58569		☐ Male	☐ Female	☐ Other	☐ English	☐ French

Last Name	First Name	Date of Birth
		Month Day Year

Mailing Address	City	Province	Postal Code

Phone Number	Cell Phone	Email Address

Patient and Prescription Information Section

Patient Code – Relationship to Member Member – 00 Spouse – 01 Child – 02

Patient's Initial	Patient Code	Date Of Birth	Drug Identification # (DIN)	Quantity	Prescription # (RX#)	Dispense Date	Dispensing Fee	Submitted Amount
	Select On	Month Day Year				Month Day Year		
	Select On	Month Day Year				Month Day Year		
	Select On	Month Day Year				Month Day Year		
	Select On	Month Day Year				Month Day Year		
	Select On	Month Day Year				Month Day Year		
	Select On	Month Day Year				Month Day Year		

Authorization—Signature Required Below

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement 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 supplier for the entire amount.

_____ Month / Day / Year _____

Signature of Member **Date Signed**