MANITOBA BLUE CROSS®

Ambulance/Medical Transfer Service Claim Form

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM.

- PLEASE ATTACH ITEMIZED RECEIPTS/INVOICES AND PRESCRIPTIONS/REFERRALS (IF REQUIRED).
- RECEIPTS WILL NOT BE RETURNED.
- CLAIMS MUST BE SUBMITTED WITHIN TWO YEARS OF DATE OF SERVICE, UNLESS OTHERWISE SPECIFIED IN POLICY PROVISIONS.

MEMBER INFORMATION

Certificate Number / Client Number	**Has your address changed?** Yes ☐ No ☐ Some plans require address changes be requested through the employer only.
Last Name / First Name	Are any expenses the result of an accident? Yes ☐ No ☐ If Yes, please complete the following:
Address	Where did the accident occur? Work ☐ Vehicle ☐ Other ☐
City / Province / Postal Code	Accident details: (if extra space is required, attach an additional page)
Email Address / Phone Number	

COORDINATION OF BENEFITS

A. Are any benefits provided under another Manitoba Blue Cross Plan? Yes ☐ No ☐

If yes, please provide the certificate number of the other plan_____

B. Are any benefits provided under any other insurance carrier Yes ☐ No ☐
If yes, please provide the following information:

Name of the other insurance carrier_____ Policyholder name _____

Effective date of coverage_____ Are all family members covered under this policy? _____

If no, please indicate which members are covered:_____

What coverage does the other plan provide? ☐ Ambulance ☐ Dental ☐ Health ☐ Hospital ☐ Prescription Drugs ☐ Vision ☐ HSA

If Manitoba Blue Cross is second insurer, please attach an explanation of benefits from first insurer.

SERVICE RECIPIENT INFORMATION

For additional service recipients, please use another claim form.

Service Recipient's Name	Birth Date (dd/mm/yyyy)	Relationship to Member	Total Amount Claimed ($)

CLAIM DETAILS (TO BE COMPLETED BY THE PROVIDER OF SERVICE OR ATTACH AN ITEMIZED RECEIPT OR INVOICE)

Account/Call Number	Date of Service (dd/mm/yyyy)	Time ☐ AM ☐ PM	Transported from Personal Care Home ☐ Yes ☐ No	Transported to Personal Care Home ☐ Yes ☐ No

Is the patient ☐ Resident ☐ Non-Resident

Is this a walking patient? ☐ Yes ☐ No

Are the services? ☐ Emergency ☐ Non-Emergency

If Non-Emergency please state the name of the physician who authorized the trip: _____

COMPLETE THIS SECTION ONLY IF PAYMENT IS TO BE MADE TO THE SERVICE PROVIDER

Provider Number: _____ Provider Name: _____

Address: _____ City & Province: _____ Postal Code: _____

HEALTH SPENDING ACCOUNT (if applicable)

☐ **Check here if you would like to request any unpaid balances from this claim to be paid using your Health Spending Account**

You must claim all medical expenses through your provincial and group insurance plans before payment can be made from a Health Spending Account. Only medical expenses recognized by Canada Revenue Agency are eligible, and payments will only be issued to the member.

AUTHORIZATION AND CONSENT

☐ I have read and understood the Authorization & Consent on the reverse side of this claim form. I confirm this claim is true and correct and that the service recipient is eligible for coverage per the agreement in place. 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 provider for the cost of the treatment(s).

Member or Service Recipient Signature_____ Date_____
(or Parent/Guardian)

Please see reverse for contact information and how to submit your claim.

Received Date

AUTHORIZATION & CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross 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 to manage the company'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 third parties include other Blue Cross Plans, 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 my policy or the group policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.

I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.888.596.1032 or mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

HOW TO SUBMIT YOUR CLAIM

Online:	mybluecross@ account at mb.bluecross.ca	In Person/ Drop Box:	599 Empress Street Winnipeg, MB
Mail:	PO Box 1046 Stn Main Winnipeg, MB R3C 2X7	Fax:	204.772.1231

Inquiries? Email through Contact Us at mb.bluecross.ca or phone 204.775.0151 or 1.888.596.1032 (toll free)

®*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, independently licensed by Manitoba Blue Cross.
†Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. 2023-0201