THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

HEALTH CARE BENEFIT CLAIM FORM

INSTRUCTIONS: Bills or receipts must be attached for each expense and fully itemized in the space provided below.

IMPORTANT: a) Part 1 must be completed and signed by the Member before your claim can be processed.

b) If any of the requested information in Parts 1 to 5 is missing or incomplete, this claim may be returned.

c) Send claim to: THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN, ADMINISTRATION OFFICE
16214 - 118 AVENUE, EDMONTON, ALBERTA T5V 1M6
TELEPHONE: 780-452-1331

d) Claims must be submitted within 12 months of date of service.

PART 1 - MEMBER'S STATEMENT AND AUTHORIZATION

MEMBER'S NAME	DATE OF BIRTH
APT/UNIT # STREET ADDRESS	
CITY/PROVINCE	POSTAL CODE
SOCIAL INSURANCE NUMBER	Is this a new address since last claim? Yes ☐ No ☐
1. Are you or any other member of your family entitled to visioncare or medical benefits under another plan? Yes ☐ No ☐	
If yes, name of family member covered under another plan	Relationship to Member
Name of other plan and policy number	
2. If yes to question 1 above, and the patient is a Dependant child, give Spouse's birthdate (Day/Month) _____	

AUTHORIZATION AND SIGNATURE:
I certify that if this claim is being made on behalf of my Spouse and/or Dependants, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any. I certify that the information given is true correct and complete to the best of my knowledge. I authorize the use of my Social Insurance Number for claim identification purposes only. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

DATE _____ **MEMBER'S SIGNATURE** _____

PART 2 - VISIONCARE STATEMENT

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Spouse/Dependant, does the patient reside with you? Yes ☐ No ☐	
If Child 18 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours work per week _____	
1. Is this your first pair of glasses/contact lenses? Yes ☐ No ☐ If no, please advise if the prescription has been changed Yes ☐ No ☐	
2. If no, to question 1, provide the approximate date the last pair was obtained.	

PART 3 - TO BE COMPLETED BY MEMBER OR PROVIDER OF MATERIALS WITH RECEIPT AND PRESCRIPTION DETAILS ATTACHED

1. Date of Service _____
2. Charge for Glasses $ _____
3. Charge for Contact Lenses $ _____
4. Charge for Safety Glasses $ _____
5. Charge for Laser Eye Surgery $ _____
6. Other _____
7. Give reasons & specific item for other charges in question 6
(ie: hardening, tinting, varigray, oversize lenses, etc.)
_____
_____
8. Name of prescribing optometrist or ophthalmologist
-if signed by optician _____

PART 4 - MEDICAL EXPENSE STATEMENT ***(please itemize expense by patient)***

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Spouse/Dependant, does the patient reside with you? Yes ☐ No ☐	
If Child 18 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours worked per week _____	

DRUG CHARGES

PRESCRIPTION (Rx) #	DATE OF PURCHASE	NAME OF PRESCRIBED DRUG OR D.I.N REQUIRED	NATURE OF ILLNESS (Only when requested)	CHARGE

OTHER EXPENSES

PROVIDER OF SERVICE	DATE OF SERVICE	TYPE OF SERVICE	CHARGE

PART 5 - MEDICAL EXPENSE STATEMENT ***(please itemize expense by patient)***

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Spouse/Dependant, does the patient reside with you? Yes ☐ No ☐	
If Child 18 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours worked per week _____	

DRUG CHARGES

PRESCRIPTION (Rx) #	DATE OF PURCHASE	NAME OF PRESCRIBED DRUG OR D.I.N REQUIRED	NATURE OF ILLNESS (Only when requested)	CHARGE

OTHER EXPENSES

PROVIDER OF SERVICE	DATE OF SERVICE	TYPE OF SERVICE	CHARGE

Member's authorization in Part 1 must be completed