MEDAVIE BLUE CROSS™

PAYMENT ASSIGNMENT FORM

* Please ensure all areas of this form are complete, and supporting documents are attached.

MEMBER INFORMATION

ID Number: _____ Policy Number: _____

Member Name: _____ Telephone Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Patient Name: _____ Date of Birth (DD/MM/YY) : _____

MEMBER STATEMENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Signature of Patient: _____ Date: _____

(if under 18 years of age, the signature of member/parent/legal guardian is required)

PROVIDER INFORMATION

Provider Name: _____ Provider Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.

Total fee for the product(s) or service(s) received: $_____ (invoices must be attached)

Signature of Provider: _____ Date: _____

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces	Quebec	Ontario	Other Provinces and Territories
PO Box 220	PO Box 3300 STN B	PO Box 2000 STN A	PO Box 2318 STN Main
Moncton NB E1C 8L3	Montreal QC H3B 4Y5	Etobicoke ON M9C 5P1	Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511

For Provider Use Only

Your claim will only be processed once your coverage has been verified. Please verify if your insurance covers graduated medical compression socks by contacting Atlantic Blue Cross Customer Care at **1-888-227-3400.**

☐ **Tick the box once verified**

- How many pairs are you covered for per year? _____
- Date of verification: _____
- Signature: _____