

Phone (780) 452-5161

SUPPLEMENTARY HEALTH CLAIM FORM

Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent INSTRUCTIONS: 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.

1. MEMBER INFORMATION										
PLAN SPONSOR / EMPLOYER NAME	GROUP NUMBER 5801									
LAST NAME	Firs	Т НАМЕ				CERTIFICATE NUMBER/SIN				
ADDRESS		LANGUAGE DATE OF BIRTH								
		Gender Male		English	(MM/DD/YY)					
			Female		French					
Сітү		PROVIN	ICE PO		OSTAL CODE	PHONE NUMBER				
2. PATIENT INFORMATION										
Does the patient have any other coverage which would pay a benefit for this claim? Yes No										
If yes, please indicate the date of birth of the insu		(MM/DD/YY)		_					
If yes, attach photocopies of vision receipts and the co-insurance statement. Is the treatment required as the result of an accident? Yes No										
If yes, indicate the accident date, location and details on how the accident occurred.										
Is the treatment required as the result of a work related injury? Yes No										
If yes, is a claim being made for Worker's Compe	ensation benefits	? Yes	5 N	No						
CLAIM DETAILS										
Patient Name (Last, First)	Relationship to Member		of birth DD/YY)	1	Type of Service	Date of Service (MM/DD/YY)	Total Charges			
		(11111)2	56,11)							
To Assign Payment to Supplier:										
I hereby assign my benefits payable from this claim to and authorize payment directly to the supplier.										
(Name of Supplier)										
Member Signature										
I hereby authorize any healthcare provider, my plan administrato										
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 Insure/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 settlement at 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.										
SIGNATURE OF MEMBER	DATE	(MM/DD/Y	Y)							
Please return to:										
FAS Funds Administrative Service Inc.										

10154 – 108 Street, NW, Edmonton, AB T5J 1L3

Toll free: 1-800-770-2998

PHYSICIAN'S RECOMMENDATION

(FOR MAJOR MEDICAL SUPPLIES)

	1.	Patient	's Name						
4. Diagnosis of medical condition with specific reason for recommendation of medical item(s) 5. Condition of patient: Acute Chronic Palliative 6. a. Date patient first consulted you for this condition (month/day/year)	2.	Indicate activities requiring this item							
5. Condition of patient: Acute Chronic Palliative 6. a. Date patient first consulted you for this condition (month/day/year)	3.								
A region actively treating this patient for this condition (month/day/year) A region actively treating this patient for this condition Yes No If no, please provide comments One of the pest of your knowledge, what is the duration for use of the recommended item(s) For the best of your knowledge, what is the duration for use of the recommended item(s) For replacement of a prosthesis or other equipment, please provide: a. Date of prior replacement (MM/DD/YY) b. Reason for replacement (MM/DD/YY) b. Reason for replacement (MM/DD/YY) b. Reason for replacement (MM/DD/YY) (B. State device(s) and/or medical equipment required: (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. Sa result of a work related injury? Yes No (A. MDDD/Y) (D. M	4.								
a. Date patient first consulted you for this condition (month/day/year) b. Are you actively treating this patient for this condition Yes No If no, please provide comments 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of prior replacement of a prosthesis or other equipment, please provide: 8. Date of prior replacement (MM/DD/YY) 10. Reason for replacement	5.	Conditi	on of patient:	Acute	Acute Chr			Palliative	
b. Are you actively treating this patient for this condition Yes No If no, please provide comments 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item(s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To the best of your knowledge, what is the duration for use of the recommended item (s) 7. To sports purpose only? 7. To sports purpose only? 7. To purpose the the the duration for the the the recommended	6.	а	Date patient first con	sulted you for this con	ndition (mo	oth/day/year)			
8. For hospital beds only, please indicate the hours or percentage of time in bed				·					
	7.	To the	best of your knowledge	e, what is the duration	n for use of	the recomme	nded ite	em(s)	
	8.	For hos	spital beds only, please	e indicate the hours or	r percentag	e of time in b	ed		
b. Reason for replacement c. Season for replacement c. Season for replacement c. Season for medical equipment required: a. As a result of a work related injury? Yes No b. As a result of a motor vehicle accident? Yes No c. For sports purpose only? Yes No c. For sports purpose only? Yes No c. For sports purpose only? Yes No c. If no, please give reason c. Specialist c. Specialist c. Specialist c. MCDDPY c. Specialist c. MCDPY c. MCDPY c. Specialist c. MCDPY c. MCDPY c. Specialist c. MCDPY c	9.	For rep	lacement of a prosthes	sis or other equipmen	t, please p	rovide:			
10. Is the device(s) and/or medical equipment required: a. As a result of a work related injury? Yes No b. As a result of a motor vehicle accident? Yes No c. For sports purpose only? Yes No 11. Has an application been made for government funding? Yes No If no, please give reason		a.	Date of prior replacer	nent (MM/DD/YY)					
A. As a result of a work related injury? Yes No A. As a result of a motor vehicle accident? Yes No C. For sports purpose only? Yes No 11. Has an application been made for government funding? Yes No If no, please give reason		b.	Reason for replacem	ent					
 b. As a result of a motor vehicle accident? Yes No c. For sports purpose only? Yes No 11. Has an application been made for government funding? Yes No If no, please give reason	10.	Is the c	levice(s) and/or medica	al equipment required	l:				
11. Has an application been made for government funding? Yes No If no, please give reason		b.	As a result of a motor	vehicle accident?	Yes	No			
pysician's Name Physician's Signature Specialist ate (MM/DD/YY) Phone Number Phone Number Intereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Funds Administrative Service Inc. to exclusion of this claim form to the husure/Plan Administrator, its authorize release of the information contained in this claim form to the husure/Plan Administrator, its authorize release of 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 I am financially responsible to the entire amount. SIGNATURE OF MEMBER Date Please return to:	11.						No	If no, please give reason	
The Partient is responsible for securing this form and page 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 authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorize release of 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 the information given is true, correct by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount. SIGNATURE OF MEMBER Date (MWDDYY) Please return to: Please return to:	nysicia	ysician's Name		Physician's	s Signature			onei	
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	Signa	TURE OF N	Iember				DATE	(MM/DD/YY)	
Funds Administrative Service Inc.	F	A	S						
10154 – 108 Street, NW, Edmonton, AB T5J 1L3 None (780) 452-5161 Toll free: 1-800-770-2998 Fax (780) 452-5	hone	(780) 45	2-5161				5J 1L3	Fav (780) 15	2-52