ALBERTA BLUE CROSS®
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Government of the Northwest Territories
Optical Services
CLAIM FORM

PROVIDER INFORMATION

Name	Telephone number	Provider number

Address	City / Town	Postal code

PATIENT INFORMATION

Last name	First name	Patient Date of Birth YYYY M M DD

NWT Health care plan number

PRESCRIPTION INFORMATION

DIST		Sphere	Cylinder	Axis	Prism	ADD
	R					
	L					

Comments / Clinical indications / Reason for replacement:

☐ Single Vision ☐ Bifocal or: ☐ Reading ☐ Distance ☐ Other: _____ Lenses: ☐ Glass ☐ Plastic ☐ Contacts

CLAIM INFORMATION

Quantity	Benefit code	Description	Left	Right	Unit cost	Amount

Date of service YYYY MM DD	**Prior approval number**	**Claim total**

ACKNOWLEDGEMENT AND CONSENT

I certify that the information contained in this and other documents supporting this claim is true and complete. By submitting this form, I understand that payment for the listed expenses will be made to the provider, in accordance with the benefit plan guidelines. I understand that the expenses listed may not be covered by, or may exceed, the plan benefits.

I understand that the personal information provided herein, as well as other personal information currently held by Alberta Blue Cross, will be used to determine eligibility for this benefit; verify, assess and pay claims; and administer the benefit plan. I hereby acknowledge and agree that my personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time and acknowledge that should I do so, my claim may not be considered. 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.

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

_____ _____
Patient's (or Parent/Guardian if Patient is under 18 years of age) Signature (required) Date

PRIVACY STATEMENT

The information on this form is being collected and used according to the federal privacy legislation for the purpose of adjudicating payment for the items listed on this form. The personal information provided herein will be kept confidential and secure. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross Privacy Matters representative toll free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009-108 Street, Edmonton, Alberta, T5J 3C5.

PROVIDER'S SIGNATURE

I hereby certify that I have rendered the above goods and / or services to the patient named above in accordance with all the stipulations of the Program.

_____ _____
Signature Date