Canadian spectrum

Health Plan Services

Mail claim to:

144 Mount Blakiston Bay
Lethbridge, Ab., T1K 6K9
Ph. (403) 380-2446 Fax (403) 802-8281
Web site www.cspectrum.ca

How to use this claim form.

1. Completely fill in all spaces on claim form.
2. Attach all receipts with claim form.
3. Forward claim form and receipts to employer.
4. Employer sends claim form, receipts and cheque for total below to Canadian Spectrum.
5. Canadian Spectrum will confirm eligibility of claims as per Health Plan Contract.
6. Canadian Spectrum will mail cheque back to eligible employee to reimburse for eligible claim.

Employee Name _____

Mailing Address _____

City _____ Prov._____

Postal Code._____ S.I.N._____

Hm. Ph._____ Wk. Ph._____

Employer _____

Item: Each item claimed must be entered separately. **Date:** The date item claimed was performed.
Patients Name: The name of the patient who received the service or material. **Relationship:** Patients Relationship to employee. Self/Spouse/child
Explanation: Explain the type of service or material purchased. For example, Chiropractor, Dentist, Optometrist, prescription, crutches, eye glasses, etc.
Purchased by: What Doctor performed the procedure or who was the prescription or other material was purchased from.
Total: Total on the bill or receipt. **Amount Claimed:** The difference (if any) between the total bill and the amount covered under this plan.

ITEM	DATE	PATIENTS NAME	RELATIONSHIP	EXPLAINATION	PERFORMED OR PURCHASED BY	TOTAL	AMOUNT CLAIMED
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							

I authorize the release of any information requested in respect of this claim to Canadian Spectrum or their agents. If claiming to another policy, I will not claim more than 100% of any claim. I certify that the information given is true, correct and complete to the best of my knowledge. I consent to the use of my S.I.N. and any claim information for the administration of the benefits under this policy.

Subtotal	
10% Administration Fee	
7% G.S.T. on Administration Fee	
TOTAL	

Date _____ Signature of Employee _____