

MANITOBA INTERNATIONAL STUDENT HEALTH PLAN MEDICAL SERVICES CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM.

- PLEASE ATTACH **ORIGINAL** ITEMIZED RECEIPTS/INVOICES. KEEP COPIES FOR YOUR RECORDS.
- ENSURE THE FIRST AND LAST NAME RECORDED ON THIS FORM APPEAR EXACTLY AS THEY DO ON YOUR MISHP COVERAGE CARD.
- CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN **6 MONTHS** OF THE DATE OF SERVICE.

SERVICE RECIPIENT INFORMATION

Certificate Number 	Client Number 8 0 9 3	Birth Date (DD/MM/YYYY)
Medical Coverage Identification (MCI) Number I 0		Are any expenses the result of an accident? Yes ☐ No ☐ If Yes, please complete the following:
Last Name on MISHP Card	First Name on MISHP Card	Where did the accident occur? Work ☐ Vehicle ☐ Other ☐
Address (while attending University)		Accident details: (if extra space is required, attach an additional page)
City	Province	Postal Code
Email Address		

Do you have medical coverage from your country of origin while studying in Canada? Yes ☐ No ☐

ISSUE PAYMENT TO ☐ PROVIDER ☐ STUDENT

PROVIDER INFORMATION

Billing Number	Type of Provider
Last Name	First Name
Address	
City	Province
Postal Code	Telephone Number

CLAIM DETAILS

(TO BE COMPLETED BY THE PROVIDER OF SERVICE OR ATTACH AN ITEMIZED RECEIPT OR INVOICE)

Please complete these required fields.

Certain tariffs require additional information. Please complete all relevant fields.

Service Date (DDMMYYYY)	Tariff Code	ICD (Diagnosis Code)	Billed Amount

Referring Provider	Facility #	Start Time	Stop Time	# Serv	Ana Units	Bilat Indic	Split Ind	# of Pts

AUTHORIZATION AND CONSENT

☐ I have read and understood the Authorization & Consent on the reverse side of this claim form. I confirm this claim is true and correct and that the service recipient is eligible for coverage per the agreement in place. I understand that the charges listed may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the provider for the cost of the treatment(s).

Service Recipient Signature _____ Date _____
(or Parent/Guardian for dependant children)

Please see reverse for contact information and how to submit your claim.

Received Date

AUTHORIZATION & CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross's privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or 1.888.596.1032 or mb.bluecross.ca.

I understand Studentcare will collect, use, and disclose my personal information for the purposes of managing eligibility for coverage under the Manitoba International Student Health Plan. To learn more about their privacy policies, I may contact Studentcare at privacy@studentcare.net.

HOW TO SUBMIT YOUR CLAIM

Email: info@mb.bluecross.ca

**In Person/
Dropbox:** 599 Empress Street
Winnipeg, MB

Mail: PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

Fax: 204.788.5599

Inquiries? Email through Contact Us at mb.bluecross.ca or phone 204.788.6800 or 1.888.596.1032 (toll free)

