Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Traditional Plan Claim Form

Send to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

INSTRUCTIONS

- **Complete part A. Complete part B where applicable. Enter all claims information in part C. Mail/Fax or email to Health Risk at the addresses above. Missing information may result in claims not being adjudicated and all receipts returned to you.**
- **Your initials and signature are required in the Authorization and Declaration section to process your claim.**

AUTHORIZATION AND DECLARATIONS

YOUR PRIVACY – Respecting and Protecting your Personal Information

At Health Risk Services we recognize and respect the importance of privacy. When you apply for coverage, we will establish a confidential file that contains your personal information. The information that we collect will be used for the purposes of determining your eligibility for coverage for the plan you are applying for and for the administration of this plan. This would include investigating and assessing claims, and creating and maintaining records concerning our relationship. Your file will be kept in the office of Health Risk Services. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Health Risk Services. We limit access to personal information in your file to Health Risk employees, to persons you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. To review the entire Health Risk Services Privacy Guidelines, visit the Health Risk website: www.healthrisk.ca – Privacy Guidelines

- I hereby apply for reimbursement of enclosed expenses under the group benefits plan sponsored by my employer and administered by Health Risk Services.
- I have read and understood the contents of the section on this form entitled - 'Your Privacy – Respecting and Protecting your Personal Information'.
- If applying for reimbursement for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I agree that a photocopy or electronic copy of the Authorization and Declarations section is as valid as the original

BY INITIALING HERE, I HEREBY AUTHORIZE:

*Required	Health Risk Services, any healthcare provider, my plan administrator, other insurance or re-insurance under the plan, if applicable; companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with Heath Risk Services to exchange personal information, when necessary to determine my eligibility for coverage and to continue to administer the plan.

SIGNATURE

I certify that all information I have given is true, correct and complete to the best of my knowledge. I understand that the submission of fraudulent claims is a criminal offence. Suspected fraudulent claims may be reported to the employer/plan sponsor and to the appropriate law enforcement agency.

Plan Member Signature:	Date Signed: (mm/dd/yyyy)

A. EMPLOYEE INFORMATION

Company Name:			**Group Number:**
Last Name:	**First Name:**		**ID Number:**
Street Address:		**Unit #:**	**PO Box:**
City:	**Province:**		**Postal Code:**

B. COORDINATION OF BENEFITS

Are you or your spouse covered by another group or supplementary health insurance plan? If "Yes" complete the following information: ◯ Yes ◯ No

Policy Holder Name:	**Name of Insurer:**	**Policy Number:**	**Coverage Type:** ◯ Single ◯ Family

Are any claims the result of the following: A work related injury? If "Yes" complete the following information: ◯ Yes ◯ No **A motor vehicle accident?** ◯ Yes ◯ No

Name of Injured	**Date of Accident: (mm/dd/yyyy)**	**Is claim being made for Workers Compensation Benefits?** ◯ Yes ◯ No

In order to process a claim, a copy of OR the original receipt must be attached. If Health Risk is the second payer then a copy of the receipt along with the Explanation of Benefits from the primary payer is required. Retain copies of your original receipts for your records.

C. CLAIMS INFORMATION

Patient's Full Name (Individual that incurred the expense)	Patient's DOB (mm/dd/yyyy)	Relationship to Employee	Type of Expense (Dental, Drugs, Vision etc…)	Date of Service (mm/dd/yyyy)	Amount $
				TOTAL	$ 0.00

HOW DO I SUBMIT CLAIMS?

In order to be reimbursed for eligible medical and dental expenses the following forms and supporting documentation must be submitted to Health Risk Services Inc.

Prescription Medications
- Health Risk Claim Form with original signature
- Original computerized Official Prescription Receipt with Pharmacist signature or stamp

Dental Claims
- Health Risk Claim Form with original signature
- Original Standard Dental Claim Form, including the Dentist's signature or stamp

Vision Claims
- Health Risk Claim Form with original signature
- Copy of Original Prescription for Eyeglasses or Contact Lenses
- Original receipt of payment

Paramedical Services (i.e. Chiropractic, Chiropodist, RMT, etc.)
- Health Risk Claim Form with original signature
- Original receipt from the licensed Medical Practitioner, including all the following information:
  - Practitioner, Address and Phone Number
  - License number and credentials of the Medical Practitioner
  - Patient Name Date of Service
  - Amount of money paid
  - Description of service or treatment
  - Signature or stamp of the licensed Medical Practitioner who performed the service

HOW DO I SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS?

When submitting your claims you should send them to the primary carrier first (i.e. you send your claims to Health Risk and your spouse's claims go to their insurance carrier). If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other insurance company with the original Explanation of Benefits (EOB) and copies of the receipts. Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year, If the parents have the same date of birth then the claims will be based on alphabetical order of the parent's first name.

If Health Risk is the second payer then a copy of the original receipt along with the Explanation of Benefits from the primary payer is required. If the EOB is for a Dental claim, the EOB should contain procedure codes, tooth codes, tooth surfaces and provider information; If the EOB does not contain this information please submit a copy of the standard dental claim form along with the EOB.

SHOULD I KEEP COPIES OF MY ORIGINAL RECEIPTS?

Always retain copies of your original receipts for your records.

WHERE DO I SEND CLAIMS?

All claims and supporting documentation must be sent to Health Risk at:

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Calgary AB T2Z 4H3
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Did you know most claims can be submitted online or through mobile app?

Go to www.healthrisk.ca and sign up today!