

PO Box 2200, Halifax NS B3J 3C6 Inquiries: 1-800-667-4511



NOVA SCOTIA INTERNATIONAL STUDENT PLAN CLAIM FORM

MEMBER INFORMATION (PI	ease provide address of residence in No	ova Scotia)					
ID Number:	Policy No 10652	School					
Student: Last Name:	First Nar	ne:					
Address:		_ City:	Prov: Postal Coo	de:			
	E-mail: _						
Host Family: Last Name:	First Nar	me:					
OTHER INFORMATION							
If Yes, complete the following: Did the accident happen as a result of an If yes, complete the following: Date of accident: Brief description of accident:	Yes No If No, skip to next Section automobile accident? Yes No Location o part due to the fault of another party? Yes No						
If yes, provide the following: Has a claim been made to recover damages from the responsible person(s)? Please provide the name, address and telephone number of your lawyer:							
CLAIM INFORMATION - To b	e completed by provider						
Provider Name:	Provider No	Telephon	e:				
Address:		City:	Prov: Postal Coc	le:			
Patient Name:		Date of Birth (DD/MM/YYY	Y):				
Date of Service DD MM YYYY	Type of Service	Name of Prescriber / Recommender	Provincial Service Code (if applicable)	Charges			
			TOTAL CHARGES				
The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from, and make copies of any records pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.							
Signature of Provider:			Date:				
ASSIGNMENT OF PAYMENT	•						
, , , , , , , , , , , , , , , , , , , ,	this claim to the named provider and authorize payment dinat I am financially responsible to the provider for the entire n: X	,	nat the fees listed on this claim may n	ot be covered or may			
PATIENT (HOST/GUARDIAN) STATEMENT							
I hereby authorize the health care provider identified below to release to Medavie Blue Cross any medical information about me and my dependents which relates to claims submitted by us, or on our behalf, to Medavie Blue Cross. I hereby certify that the services listed have been rendered and that any information relating to these services, and supporting documentation of this information, may be obtained by Medavie Blue Cross for verification purposes.							
Company of Canada, may be collected, us me, and to manage Blue Cross's business. other Blue Cross organizations, health care	n provided herein, as well as any other personal information c sed, or disclosed to administer the terms of my policy or the . Depending on the type of coverage I carry, limited personal e professionals or institutions, life and health insurers, govern ister and manage the benefits outlined in the policy of which	group policy of which I am an eligible information may be collected from a nment and regulatory authorities, the	e member, to recommend suitable pro and/or released to a third party. These	ducts and services to third parties include			
I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.							
Signature of Patient / Host / Guardian: X Date:							
(If under I8 years of age the signature of the Host / Guardian is required.)							
This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.							
Please ensure all areas are complete. Please ensure all original supporting receipt/invoices are attached, if applicable.							

A direct deposit form must be submitted for reimbursement claims. ¹¹ The Blue Cross symbol and name are registered trademarks of the Canadian Association of Blue Cross Plans, used under licence by Medavie Blue Cross, an independent licence of the Canadian Association of Blue Cross Plans.



Your money belongs in your wallet, not in the mail.

Direct Deposit gets it in your bank account sooner!

Sign up today:

- 1. Visit <u>www.medavie.bluecross.ca</u>
- 2. Select "<u>Plan Members</u>" in the upper right-hand corner
- 3. Select "Go to secure site"
- 4. Select "<u>Member</u>"
- 5. Enroll by clicking the "Banking" link



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NSISP - REQUEST FOR DIRECT DEPOSIT

□ New Request □ C	Change Effective:	Immediately	or 🗅 _	(specify future date)		
MEMBER INFORMATION							
Name:							
Policy Number: Identification Number:							
Telephone:	bout this request, how can						
		L INSTITUTION IN					
		E CHEQUE MARK		FRF			
		OR					
IF CHEQUE IS NOT AVAILABLE, COMPLETE INFORMATION BELOW:							
Name of Bank:							
Bank Address:							
Financial Institution Nu	mber:	Bra	anch Number: <u>.</u>				
Account Number:							
I request my benefits be	e paid through electronic function in the paid through electronic function is a set of the paid of the	nds transfer (direct	deposit) into tl				
Student Signature:			Date (yyyy/mi	m/dd):			
		INSTRUCTIONS	`				
	eposit when first enrolling i your plan administrator, al			ed Request for Direc	ct Deposit form		
If requesting direct deposit in conjunction with a claim, mail completed Request for Direct Deposit form and void cheque along with your claim to your nearest Medavie Blue Cross office.							
* Otherwise, mail completed Request for Direct Deposit form and void cheque to your nearest Medavie Blue Cross office.							
* If your banking arrangements change, please complete a new Request for Direct Deposit form and mail with a void cheque to your nearest Medavie Blue Cross office.							
* If you would like to terminate your direct deposit arrangement, please advise us in writing. Send your written request to your nearest Medavie Blue Cross office.							
authorize payment to be	stitution Information belong paid through electronic fu by giving written notice to	nds transfer (direct	deposit) into t				
Student Signature:			Date (yyyy/m	m/dd):			
MEDAVIE BLUE CROSS OFFICES							
Atlantic Canada 644 Main St.	Quebec 550 Sherbro	oke St. West		Dntario 185 The West Mall	Suite 1200		

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