

MEDICAL EXPENSE CLAIM FORM !! Please print clearly. Thank you. !!

① Primary Insured Information: *The International Student or Staff Member*

Last Name:		First Name:		Date of Birth: mm/dd/yyyy
Telephone #:		Name of School:		Policy # on Insurance ID Card:
Insurance Effective Date:	Insurance Expiry Date:	Email Address:		
Do you have Other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you want Norfolk Mobility Benefits Inc. to set up a confidential online account for you where you can look up your claims history & status? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you making a claim with this other insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you answer 'Yes', the LOGIN username and password for your confidential online account on the Norfolk Network will be emailed to you at the email address you provide above.		
If Yes, give name and telephone number of Insurer, and Policy Number: _____				

② Patient Information: (The person who received the medical services being claimed)

Last Name:		First Name:		Date of Birth: mm/dd/yyyy
Has the patient had the same or similar medical conditions in past 90 days? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, give details incl. when symptoms first occurred and history of treatment:</i>				
Were medical services needed due to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, provide details including date and location of accident:</i>				

③ Medical Services / Expenses Information:

Date of Service	Medical Provider Name	Symptoms / Reason for Treatment & Medical Diagnosis	Cost \$

④ For Medical Providers Only

<input type="checkbox"/> Was a Prescription given? <input type="checkbox"/> X-ray Ordered? <input type="checkbox"/> Lab Work Ordered? <input type="checkbox"/> Other Referral? _____		
Doctor's Name PRINT	Date	Dr.'s Signature (only required if Dr. submits for direct payment)

⑤ Who should the claim payment be made to, and How?

Name: Mailing Address: Tel ()	Method of Payment: Choose One Only <input type="checkbox"/> Mail Cheque Payment <input type="checkbox"/> Direct Deposit (Electronic Funds Transfer) Direct Deposit is possible <u>only to a Canadian Bank Account</u> , You must provide a copy of a Voided Cheque with your claim.
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⑥ Declaration and Authorization

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I authorize any hospital, physician, other medical provider or insurer to provide by any means (including fax, mail or email) my complete medical records to Norfolk Mobility Benefits for the purpose of administering claims. **I authorize payment to be made to the party named above for all expenses claimed on this form.**

I certify that the above information is true: _____
 Signature of Primary Insured Date mm/dd/yyyy

Claims under \$2500 may be sent by fax or email. If the claim is over \$2500, original hard copies must be sent. Keep record of your claims for 24 months.	Submit claims to: Norfolk Mobility Benefits Inc. Suite 300, 999 – 8 th Street S.W. Calgary AB Canada T2R 1J5 Fax: 403-265-9425 Email: claims@norfolkmobility.com	Questions? Norfolk Mobility Benefits Call 1-866-767-5928 David Cummings Insurance Services Call 604-228-8816
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