

## **HSA Claim Form**

Mail To: Benecaid Health Benefit Solutions Inc. Attn: Claims Department P.O. Box 40 Toronto, ON M9C 4V2

Complete section 1. Enter all claims information in section 2. Complete section 3 if you are an hsa*complete*<sup>™</sup> policy holder. <u>Sign</u> section 4. Mail to Benecaid at the <u>address above</u>. Incomplete forms will not be adjudicated and will be returned to you without reimbursement. If your direct deposit banking information has changed please notify Benecaid prior to submitting your claim.

Patients Name (Individual that incurred the expense) Patients Name Patie	_				_	<u> </u>					
Please ensure that all of your member and claim information is completed in full. Failure to do so may result in your claim being returned or rejected for additional details.  In order to process a claim the riginal recipit must be stashed. It Beneasil is the second payer then a photocopied recept along with the original Explanation of Benefits for the primary payer is required. Retail photocopies of your original recipits for your records.  Patient's Parent's Payer is required. Retail photocopies of your original recipits for your records.  Retailcraship to Contact Though the photocopies of your original recipits for your records.  Retailcraship to Contact Though the photocopies of your records.  Retailcraship to Contact Though the photocopies of your records.  Retailcraship to Contact Though the photocopies of your records.  YMY MIN DD  YMY MIN	0	Company Name:						Group Policy #:			
Please ensure that all of your member and claim information is completed in full. Failure to do so may result in your claim being returned or rejected for additional details.  In order to process a claim the agginal receipt must be attached. If Beneatid is the second payer then a photocopied receipt along with the original Explanation of Benefits from the privary payer is required. Receipt must be attached. If Beneatid is the second payer then a photocopied receipt along with the original Explanation of Benefits from the privary payer is required. Receipt must be attached by the privary payer is required. Receipt must be attached. If Beneatid is the second payer then a photocopied receipt along with the original Explanation of Benefits from the privary payer is required. Receipt must be attached by the privary payer is required. Receipt must be attached by the privary payer is required. Receipt must be attached by the privary payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the payer is required. Receipt must be attached by the other insurer along with copies of the receipts.  It must be a payer is required. Receipt must be payer is required. Receipt must be a payer is payer and the payer is required. Receipt must be a payer is payer and payer is payer and payer is payer. Receipt must be payer in payer is payer. Receipt must be payer in payer. Receipt must be payer in payer in payer in payer in payer in payer in payer. Payer in payer in payer in payer in payer in	EE INF	Last Name: First Name:						Client ID:			
Please ensure that all of your member and claim information is completed in full. Failure to do so may result in your claim being returned or rejected for additional details.  In order to process a claim the riginal recipit must be stashed. It Beneasil is the second payer then a photocopied recept along with the original Explanation of Benefits for the primary payer is required. Retail photocopies of your original recipits for your records.  Patient's Parent's Payer is required. Retail photocopies of your original recipits for your records.  Retailcraship to Contact Though the photocopies of your original recipits for your records.  Retailcraship to Contact Though the photocopies of your records.  Retailcraship to Contact Though the photocopies of your records.  Retailcraship to Contact Though the photocopies of your records.  YMY MIN DD  YMY MIN	MPLOY	Street Address:					Unit #:		PO Box:		
In order to process a claim the <u>original</u> receipt must be attached. If Benecoal is the second payer then a photocopied receipt along with the <u>original</u> Explanation of Benefits for the primary payer is required. Retain photocopies of your original receipts for your receipts.    Patient's Name		City:				Province:		Postal Co	l ode:		
In order to process a claim the <u>original</u> receipt must be attached. If Benecoal is the second payer then a photocopied receipt along with the <u>original</u> Explanation of Benefits for the primary payer is required. Retain photocopies of your original receipts for your receipts.    Patient's Name	Please ensure that all of your member and claim information is completed in full. Failure to do so may result in your claim being returned										
Patients Name Patients (Individual that incurred the expense)  Patients Name Patients (Patients Name Patients)  Patients (Patients)  Pa	or rejected for additional details.										
Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only   TOTAL		n order to process a claim the <u>original</u> receipt must be attached. If Benecaid is the second payer then a photocopied receipt along with the <u>original</u> Explanation of Benefits from the primary payer is required. Retain photocopies of your original receipts for your records.									
Co-ordination of Benefits for hsacompleter® Policy Holders only  TOTAL    Co-ordination of Benefits for hsacompleter® Policy Holders only					])		.)				
TOTAL    Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only	N		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only	MATIC		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only	FOR		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only	MSIN		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete** Policy Holders only	CLAII		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete <sup>TM</sup> Policy Holders only	.2		YYYY MM DD				Y	YYY MM DI	D		
TOTAL    Co-ordination of Benefits for hsacomplete™ Policy Holders only   Are you or your spouse covered by other health insurance plans? Please provide details below.    Name of Policy Holder			YYYY MM DD				Y	YYY MM DI	D		
Are you or your spouse covered by other health insurance plans? Please provide details below.  Name of Policy Holder  Name of Insurer  Policy Number  Coverage Type (Single/Couple/Family)  How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of their receipts.  It claim is for your policy in the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  It certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authori Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers and the insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information in a wall and a second and its insurance providers and the parent when the parent when the paren			YYYY MM DD				Y	YYY MM DI	D		
Are you or your spouse covered by other health insurance plans? Please provide details below.  Name of Policy Holder  Name of Insurer  Policy Number  Coverage Type (Single/Couple/Family)  How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of their receipts.  It claim is for your policy in the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  It certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authori Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers and the insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information in a wall and a second and its insurance providers and the parent when the parent when the paren								TOTA	1		
Are you or your spouse covered by other health insurance plans? Please provide details below.  Name of Policy Holder  Name of Insurer  Policy Number  Coverage Type (Single/Couple/Family)  How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  It certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any, I authorized to disclose information and administrator, other insurance companies, other organizations, or benefit											
Are you or your spouse covered by other health insurance plans? Please provide details below.  Name of Policy Holder  Name of Insurer  Policy Number  Coverage Type (Single/Couple/Family)  How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorized to its advisors and service providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Signature:  Date Signet:											
Name of Policy Holder  Name of Insurer  Policy Number  Coverage Type (Single/Couple/Family)  How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  It certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorized to its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Signature:  Date Signed:		Co-ordination of Benefits for hsa <i>complete</i> ™ Policy Holders only									
How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorize working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administre the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Signature:  Date Signed:		Are you or your spouse covered by other health insurance plans? Please provide details below.									
How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorized working with Benecaid and its insurance providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Date Signed:	ш	Name of Policy Holder		Name of Insurer		Policy Number		Coverage Type (Single/Couple/Family)			
How to submit a claim when there is more than one insurer:  If the claim is for you, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefit returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorized working with Benecaid and its insurance providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Date Signed:	PLET										
If the claim is for your spouse, submit to your other insurer(s) first then provide Benecaid with the original Explanation of Benefits returned by the other insurer along with copies of your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefice returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorised benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Signature:  Date Signed:											
your receipts.  If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benef returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authori Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Date Signed:	3. HSA										
returned by the other insurer along with copies of their receipts.  If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit the alphabetical order of the parent's first names.  I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorized working with Benecaid and its insurance providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.  Signature:  Date Signed:		your receipts.  • If the claim is for your spouse, submit first to the other insurer(s) under which they are covered as a participant then provide Benecaid with the original Explanation of Benefits									
eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authori Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.    Date Signed:		returned by the other insurer along with copies of their receipts.  • If the claim is for your child, first submit under the parent whose birthday (month & day) comes first in the calendar year. If both parents have the same birthday then submit in									
Signature:  Date Signed:  YYYY MM DI	NOWLEDGEMENT	I certify that the information above is complete and true to the best of my knowledge and that the attached receipts represent a claim for services rendered to me and/or my eligible dependents. I am authorized to disclose information about my dependents for the purposes of investigating claims and assessing and paying a benefit, if any. I authorize Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance providers to exchange information when necessary to assess my claim and to administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.									
<del></del>	4. ACK	Signature:	Signature:						Date Signed: YYYY MM DD		

HSA/22-101 (12.11) Page 1 of 2



# HSA Claim Submitting Instructions

#### **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 Benecaid. Each reimbursement cheque or direct deposit is subject to a \$3.75 processing fee:

## **Prescription Medications**

- · Benecaid Claim Form with original signature
- Original computerized Official Prescription Receipt with Pharmacist signature or stamp

## Non-traditional Medications (ie. herbal remedies, vitamins and supplements)

- · Benecaid Claim Form with original signature
- Original computerized Official Prescription Receipt with Pharmacist signature or stamp OR Official Dispensing Receipt from licensed Medical Practitioner stating that the items were prescribed and dispensed as part of their medical service

### **Dental Treatments**

- · Benecaid Claim Form with original signature
- Original Standard Dental Claim Form, including the Dentist's signature or stamp

## **Optical Services**

- · Benecaid Claim Form with original signature
- Copy of Original Prescription for Eyeglasses or Contact Lenses
- Original receipt of payment

## Paramedicals (ie. Chiropractic, Chiropodist, RMT, etc.)

- · Benecaid Claim Form with original signature
- Original receipt from the licensed Medical Practitioner, including all the following information:
  - · Practitioner, Clinic Name, Address and Phone Number
  - Name of the licensed Medical Practitioner who performed the service
  - 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

### What if Benecaid is the Second Payer?

If Benecaid is the second payer then a photocopied receipt along with the <u>original</u> Explanation of Benefits from the primary payer is required.

### Should I keep Copies of my Original Receipts?

Always retain photocopies of your original receipts for your records.

## Where do I Mail Claims?

All claims and supporting documentation must be mailed to Benecaid at the following address:

Benecaid Health Benefit Solutions Inc.
Attn: Claims Department
P.O. Box 40
Toronto, ON M9C 4V2

HSA/22-101 (12.11) Page 2 of 2