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# EXTENDED HEALTH CARE and VISION CARE CLAIM

FAXED CLAIMS NOT ACCEPTED

Please answer all questions to support timely processing of your claim (see back for specific instructions).

If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy statement at [www.asebp.ab.ca/privacy.html](http://www.asebp.ab.ca/privacy.html), or contact the Privacy Officer at 780-431-4786.

COVERED MEMBER'S INFORMATION <i>(Please print)</i>							
Covered member's (employee's) name: _____							
Mailing address: _____					GROUP	SECTION	MEMBER'S ASEBP ID NO.
_____					1	9	9
_____					3	0	
Postal code: _____					Phone number: _____		
_____							
CLAIM DETAILS <i>(Attach original receipts and invoices OR the Explanation of Benefits (EOB) from the other health benefit plan)</i>							
PATIENT'S NAME	ASEBP ID NO.	BIRTH DATE (YYYY/MM/DD)	SERVICE DESCRIPTION OR PRESCRIPTION NUMBER	DATE OF SERVICE (YYYY/MM/DD)	D.I.N. (Prescriptions only)	CLAIM AMOUNT	
1.						\$	
2.						\$	
3.						\$	
4.						\$	
5.						\$	
OTHER HEALTH BENEFIT COVERAGE							
If you or your dependents have health benefit coverage through another health benefits company, insurance company or another ASEBP plan, please complete below. <i>If you claimed through the health benefit plan listed below first, please attach the EOB to this claim form.</i>							
Name of other health benefits company or insurance company: _____					<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> EHC/Prescription
_____					Coverage date (YYYY/MM/DD): ____ / ____ / ____		
Name of person holding coverage: _____					Birth date (YYYY/MM/DD): ____ / ____ / ____		
CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION							
I understand that the personal information contained in this claim form (with supporting documentation) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, verify, assess and pay claims, and administer my benefit plan. By submitting this claim form, I am requesting payment for the listed expenses based on my benefit plan guidelines.							
I understand that these expenses may not be covered or may exceed my plan benefits and that I am financially responsible to my service provider for the entire treatment. It may be necessary for ASEBP to disclose some or all personal information to its staff, any consultants hired by ASEBP, licensed physicians and/or any other health care professional or institutions, health benefit companies or insurance companies for the purposes outlined above.							
I represent to ASEBP that I have been authorized by all dependents for whom coverage is applied for through me to consent on their behalf to the collection, use and disclosure of their personal information for the above purposes or to government and regulatory authorities where required by law within provisions of the relevant privacy legislation. I understand that the personal information belonging to my dependents and myself will be kept confidential and secure.							
I may revoke my consent at any time and acknowledge that should I do so, my claim may not be considered. I understand why the information is required and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.							
I agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.							
Covered member's signature: _____					Date: _____		
ASEBP OFFICE USE ONLY			ASSIGNMENT OF BENEFITS: <i>(To pay the service provider directly)</i>				
			I hereby assign benefits payable for this claim to _____ and authorize payment directly to him/her/them. <i>(Service Provider Name)</i>				
			Address: _____				
			Covered member's signature: _____				

## CLAIM SUBMISSION REQUIREMENTS

## *FAXED CLAIMS ARE NOT ACCEPTED*

To ensure your claim is processed promptly, please read the following instructions. Your claim may be returned if any of the required information is missing or incomplete.

- A claim form must be completed by the covered member (employee) holding coverage with ASEBP (not a spouse, partner or dependent).
- **Original receipts/invoices/statements must be attached and indicate:**
  - first and last name of individual receiving the service
  - date or dates on which service was provided
  - total cost of the service
  - provider's name and address
  - if you claimed through another health benefit plan first, attach the Explanation of Benefits (EOB) to this claim form with a copy of the **original** receipt, invoice or statement
- **Note:** Credit/debit card and cash register receipts **are not** acceptable nor are photocopied receipts or faxed claims.
- **All original receipts will be retained by ASEBP and not returned to you.** Please photocopy your receipts if you require them for your records or for coordination of benefits with another benefit provider.
- Upon receipt of your cheque, please retain the cheque stub for income tax purposes as no other statement will be issued.

In addition, claims for:

- a) Vision Care require you to attach the original detailed receipt (no prescription required)
- b) Prescription medicines must include the drug identification number (DIN) on the receipt (except for out-of-country prescriptions)
- c) Ambulance service must have an original invoice/receipt showing the date of service, point of origin, and destination
- d) Claims requiring pre-approval are:
  - Home nursing care
  - Hospital beds
  - Bandages/Dressings & related supplies
  - Wigs
  - Medical referral out-of-province

These claims must include:

- a health care provider's letter indicating diagnosis, which medical services are required, and how long they are required for
  - a letter indicating you:
    - (1) are not eligible for coverage under the government program; or
    - (2) have reached your maximum coverage under the government program
  - an original receipt/invoice including a complete breakdown of charges
- e) Mid-wifery services require an original invoice/receipt providing the date and length of each visit and delivery date
  - f) Psychology services require:
    - an original receipt/invoice indicating:
      - the length of each session
      - the amount being charged for each session
      - if more than one person is attending a session, each patient's name
  - g) Massage therapy must have the providers' name, association name, mailing address and registration number on the receipt
  - h) Accidental dental require a completed *Dental Care Claim* form clearly identifying all injured teeth, the date of the accident, and an explanation of how the accident happened. Please make sure to write "**dental accident**" across the top of the first claim form you submit.

### CLAIM SUBMISSION DEADLINE

Claims must be received by ASEBP within **18 months** of the date the expense is incurred. Claims **more than** 18 months old will not be paid. **Faxed claims are not accepted.**

Mail completed claim forms with original receipts/invoices firmly attached to:

**Alberta School Employee Benefit Plan**  
**Suite 700 Weber Centre**  
**5555 Calgary Trail**  
**Edmonton AB T6H 5P9**