Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

EXTENDED HEALTH CARE and VISION CARE CLAIM

Claims that are faxed, emailed, unsigned or do not have original receipts attached will be returned

COVERED MEMBER INFORMATION* *(Please print)*

Covered member's (employee's) name: ______________________________

Mailing address: ______________________________

Postal code: ____________ Phone number: ____________

Email: ______________________________

GROUP	SECTION	MEMBER'S ASEBP ID NO.
1 9 9 3 0		

CLAIM DETAILS* *(Attach **original** receipts/invoices **OR** the Explanation of Benefits (EOB) with a copy of the original receipts/invoices)*

PATIENT'S NAME	ASEBP ID NO.	BIRTH DATE (YYYY/MM/DD)	NO. OF ATTACHMENTS	TOTAL AMOUNT CLAIMED
1.				
2.				
3.				
4.				
5.				

ASSIGNMENT OF BENEFITS: *(Complete if you want ASEBP to pay the service provider directly)*

The following types of claims are eligible for assignment of benefits:

- Ambulance services
- Endovenous treatments
- Hearing aids
- Hospital accommodations
- Prosthetics
- Psychology services
- Respiratory equipment

Including items which require ASEBP pre-approval, such as:

- Home nursing services
- Hospital beds
- Joint injectable materials
- Wheelchairs/Scooters
- Wigs

I hereby assign benefits payable for this claim and authorize payment directly to the provider listed below.

Provider name: ______________________________

Provider address: ______________________________

Covered member's signature: ______________________________

You are still required to sign and date the consent section below if assigning payment to a provider.

OTHER HEALTH BENEFIT COVERAGE

If you or your dependants have health benefit coverage through another health benefits company, insurance company or another ASEBP plan, please complete below. *If you claimed through the health benefit plan listed below first, please attach the EOB with a copy of the original receipts/invoice to this claim form.*

Name of other health benefits company or insurance company:

____

Name of person holding coverage:

____

Coverage holder's birth date (YYYY/MM/DD):

________ / ________ / ________

Type of coverage:

☐ Dental ☐ Vision ☐ EHC/Prescription

Other coverage effective 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. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my/our eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.

Covered member/spouse's signature: ______________________________ **Date:** ______________

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. 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.ca/privacy.html, or contact the Privacy Officer at 780-438-5300 or by email at po@asebp.ca.

CLAIM SUBMISSION REQUIREMENTS — *FAXED/EMAILED 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.

- **Claims that are faxed, emailed, unsigned or do not have original receipts attached will be returned.**
- A claim form must be completed and signed by the covered member (employee) holding coverage with ASEBP or a spouse/partner (not a dependent child).
- **Original receipts/invoices/statements must be attached and indicate:**

  1) - 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, address, and, if applicable, their credentials/registration

  OR

  2) - 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/emailed 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 payment, please retain the Explanation of Benefits for income tax purposes as no other statement will be issued.

PRE-APPROVALS

Some products, many of which fall under the Medical Aids and Equipment category, require additional supporting documentation or pre-approval to facilitate claims processing. Please refer to the applicable section of the Extended Health Care online guide (found under the Benefits and Services tab) on ASEBP's website, www.asebp.ca, for claim requirements for the specific medical service or supply for which you are submitting a claim.

The following items require ASEBP pre-approval:

- Bandages and dressings*
- Joint injectable materials
- Home nursing services
- Hospital beds
- Wheelchairs/Scooters
- Wigs

*Not eligible for assignment of benefits

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/emailed claims are not accepted.**

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

Alberta School Employee Benefit Plan
Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton AB T6H 2K7

Upon receipt in our office, routine claims are processed within 5 - 7 business days.

FINDING THE MOST CURRENT VERSIONS OF ASEBP FORMS

Submitting your claim using the most current version of the *Extended Health Care and Vision Care Claim* form is important for its timely and accurate processing.

To ensure you are using the most current version of all ASEBP forms, you should visit the Forms section of our website, www.asebp.ca, before submitting it to ASEBP for processing—all forms include a date in the footer which indicates when it was last updated.