Desjardins Financial Security™

P.O. Box 3950
Levis (Quebec) G6V 8C6

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.
(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A

Name of Group	Contract No.	Certificate No.
GROUP HEALTH AND HOSPITALIZATION INSURANCE PLAN FOR FOREIGN UNIVERSITY STUDENTS	**Q178**	

Member's Last Name | Sex ☐ M ☐ F | Date of Birth YY MM DD

First Name | Middle Name(s)

Number, Street, Apartment

City, Province | Postal Code

B

If care has been provided in Canada and a claim for medical fees is being submitted, the attending physician must complete this section.

Diagnosis: (PLEASE PRINT) _____

Date	Description of Services	Diagnostic Code	Procedure Code	Fees
YY MM DD				$
YY MM DD				$
YY MM DD				$
YY MM DD				$

Name and Address of Attending Physician (PLEASE PRINT)

_____ Licence No.: _____

_____ Telephone No.: (_____) _____

_____ _____

Signature of Attending Physician | Date

C

If expenses have been incurred during a trip outside Canada, please complete this section.

Date of Departure YY MM DD

Anticipated Date of Return to Canada YY MM DD

Actual Date of Return to Canada YY MM DD

SERVICES RECEIVED – Give reason for medical or hospital services provided.

_____

Describe services received (e.g.: examination, X-rays, surgery). If you need more space, use a separate sheet.

_____

Town and country where services were rendered:

If services were required because of an accident, please specify:

Date of Accident YY MM DD

Type of Accident

☐ Automobile ☐ Work

☐ Other (specify): _____

Amount Claimed

$ _____

Canadian Currency ☐

Other Currency ☐ (Specify)

Has the bill been paid?

☐ Yes ☐ In Full ☐ In Part ▶ $ _____ Amount

☐ No

D **Is the claim the result of:**

- **a work injury?** ☐ **Yes** ☐ **No**
- **a motor vehicle accident?** ☐ **Yes** ☐ **No**
- **other?** ☐ **Yes** ☐ **No** **Specify:** _____

If so, has a claim been submitted to a government agency such as the Commission de la santé et de la sécurité du travail (CSST) or Société de l'assurance automobile du Québec (SAAQ), etc.? ☐ Yes ☐ No

E **REFUND**

Do you wish the refund to be paid to the practitioner? ☐ Yes ☐ No

IMPORTANT INFORMATION

- **Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **Claims MUST BE submitted no later than one year after expenses are incurred.**

DRUG EXPENSES

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.

MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, podiatrist, physiotherapist)
If a medical recommendation is required under the terms of your contract, please include it.

Please attach an itemized statement or a receipt stating:

- patient's name
- practitioner's name
- practitioner's licence or registration number
- type of practitioner
- length of visit
- date(s) of visit(s)
- charge for each treatment

EQUIPMENT AND APPLIANCE EXPENSES

If required under the terms of your contract (see your booklet) provide the attending physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial-plan payment summary, if applicable.

Indicate the period of time the equipment will be required: from: _____ to: _____

F **AUTHORIZATION**

I hereby authorize the information in this claim to be disclosed to my insurance company or its agents, if necessary. To the best of my knowledge, all the information I have provided on the claim form is accurate and complete.

_____ _____

Signature of member Date

Telephone No. ( )