Health Benefits Administration
Seventh-day Adventist Church in Canada
1148 King Street East, Oshawa, ON L1H 1H8
Telephone 1-800-263-7868 or 905-433-3964 • **Fax** 905-433-3717

Health Care Benefit Request

Please type or print information needed and return to Health Benefits Administration at the above address.

Employee Name

First Name | Middle Initial | Last Name

Address | Postal Code

New Address Yes ❒ No ❒ | Employee's S.I.N | **Patient's Name** | Patient's Date of Birth (Day Month Year)

Patient's Relationship to Insured Self ❒ Spouse ❒ Child ❒ Other ❒ | Full Time Student Yes ❒ No ❒

Any other Medical Benefits for Employee, Spouse or Patient? Yes ❒ No ❒

Who? ❒ Self ❒ Dependent, if Dependent or Spouse, Full Name

Coverage provided through Spouse's Plan ❒ Provincial Plan ❒ Employer Sponsored Plan ❒ Other ❒

If other is chosen, please provide information: Name of Carrier

Address | Policy Number

Was Condition Related to Patient's Employment Yes ❒ No ❒ | School Related Yes ❒ No ❒

An Accident Yes ❒ No ❒ If yes, please give date (Day Month Year)

Description (how & where)

Authorization and Certificate

You are authorized to provide to Health Benefits Administration, information concerning health care, advice and treatment, or supplies to the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I agree that a photographic copy of this authorization is as valid as the original.

I certify that the amount listed above is my actual out-of-pocket expense after all known or anticipated discounts and/or cash refunds, and that any other coverage for health care assistance by group insurance carriers, automobile insurance carriers, governmental or public agencies, or reimbursement by other employers has been deducted before submitting this report for reimbursement.

Signature ______________________________

Attach fully Itemized Statements

❒ Please reimburse employee
❒ Please pay provider *(Statements **must** include date of service and service performed.)*

Physician or Supplier Information *(Attach fully itemized statements or complete portion below. Physician/Provider signature must be included.)*

Date of Service	Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given	Total Charge	Amount Paid	Balance Due

Signature of Physician or Supplier | Physician's or Supplier's Name, Address, Postal Code & Telephone No
Is this a new address? Yes ❒ No ❒

Your Patient's Account No

How To Request Benefits

Complete the Health Care Benefit Request Form in Full
It is important that you provide all the information requested. *If you omit needed information, benefit payments could be delayed.*

Provide Proof
Original bills of providers are accepted if they are on the letterhead of the provider, or on a claim form, and contain the following information

- Name of patient and name of employee
- Date of service, treatment or purchase
- Type of treatment
- Diagnosis
- Each item or service for which you are charged
- Amount of charge

Note Non-itemized receipts or billings are not acceptable.

This claim form should not be completed for Dental or Prescription Drug claims

- Dental claims should be submitted on a Standard Dental Claim Form, available at your dentist's office or submitted electronically by your dental office through Autoben. (See the instruction sheet "Electronic Dental Claim Submission" on the Health Benefit webpage www.adventist.ca/hba.)

- Prescription drug expenses are paid directly to the pharmacy through your Health Benefit card (Express Scripts). Please remember to use your card at the pharmacy.

Important Reminder

Please be sure you provide your Certificate Number