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 don't 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) statement with a copy of the original receipts/invoices)*

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

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

Please indicate the type of claim for which you would like to assign benefits:

☐ Ambulance services

☐ Hospital rooms

☐ Oxygen (including supplies related to its use)

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're 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 ☐ Extended Health Care (Drugs, travel emergencies and other medical services & supplies)

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 section 1 of the federal *Personal Information Protection Electronic Documents Act*. Be advised that in order to optimize the services we provide we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Policy at www.asebp.ca or contact the privacy officer at 780-438-5300.

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 don't 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(s) 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) statement to this claim form with a copy of the original receipt, invoice or statement

  Note: Credit/debit card and cash register receipts **aren't** 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 EOB for income tax purposes as no other statement will be issued.

PRE-APPROVALS

Some products, many of which fall under the Other Medical Services & Supplies category, require additional supporting documentation or pre-approval to facilitate claims processing. Please refer to Other Medical Services & Supplies, found under My Benefits on our website, www.asebp.ca, for claim requirement details.

The following items require ASEBP pre-approval:

- Dressings, bandages and related supplies
- Hairpieces and wigs
- Home nursing care
- Hospital beds
- Wheelchairs/scooters

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 won't be paid. **Log in to My ASEBP to submit your claims electronically; 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

Routine paper claims are processed within 10-14 business days (5 -7 business days for online claims).

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 Forms on 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.