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		

INSTRUCTIONS

1. All receipts require an individual line in "Claim Details" to be filled out. The member's name in (A) should match the patient's name in (B).
2. For claims assigned to be paid directly from ASEBP to the service provider or have been partially paid through another benefit coverage provider, kindly fill out sections (C) and (D) accordingly.
3. All claims will be returned by ASEBP if the primary covered member or spouse, if applicable, fail to provide consent for the collection, use and disclosure of personal information, section (E).
4. All claims will be returned by ASEBP if the primary covered member or spouse, if applicable, fail to sign the receipt attachment disclaimer, section (F)

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

(A) Complete for covered member and/or all persons being claimed for on this form

Relationship to member	ASEBP ID	First name	Last name	Date of birth
Self				
Spouse				
Dependant				
Dependant				
Dependant				

(B) CLAIM DETAILS *(Attach **original** receipts/invoices **OR** the explanation of benefits (EOB) statement with a copy of the original receipts/invoices)*

PATIENT'S NAME	DATE OF SERVICE	SERVICE DESCRIPTION AND/OR D.I.N.	AMOUNT CLAIMED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
		Enter total claim amount	$

Ensure sections (C) and (D) are filled out if applicable. Section (E) is mandatory for the processing of claims. ⟶

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(C) 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. Please note that only the items listed below are assignable:

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

(D) 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):

_____ / _____ / _____

(E) CONSENT FOR THE COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

I understand that the Alberta School Employee Benefit Plan (ASEBP) must collect, use, maintain and disclose personal information for the purposes of enrolling myself and my dependants, if any, in the ASEBP benefit plans and services and for determining eligibility for coverage, assessment, paying claims, audit, investigation, and administering the benefit plan. I understand that it may be necessary for the ASEBP to disclose some or all of my personal information to third party service providers or my employer for some of these purposes as is reasonable. I acknowledge that where third party service providers are retained, ASEBP ensures that appropriate contracts or terms of service are in place to protect personal information.

By providing my email address, I understand that ASEBP may use my email address to notify me of transactions on my account, changes or information related to ASEBP and its various benefit plans and services, to provide information specifically related to my benefit coverage/utilization/experience or to conduct surveys regarding my experience with ASEBP.

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.

(F) RECEIPT ATTACHMENT DISCLAIMER

For faster and more secure processing, ASEBP strongly recommends submitting claims online through My ASEBP desktop portal, or the My ASEBP mobile app. Using physical claim forms and mailing receipts or Explanation of Benefits (EOB) carries the risk of loss, delay, or damage during transit, for which ASEBP is not responsible. If you choose to submit a physical claim, it is your responsibility to retain copies of all submitted documents for your records. To avoid potential issues, please consider using the secure and convenient online submission options at My ASEBP.

Covered member/spouse's signature: _____ **Date**: _____

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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. Receipts must be securely attached in the applicable area on the backside of this page.**
- A claim form must be completed and signed by the covered member (employee) holding coverage with ASEBP or a spouse/partner (not a dependant 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 **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 EOB for income tax purposes as no other statement will be issued.
- Ensure the receipt disclaimer is signed by the covered member, or spouse if applicable. Failure to sign the disclaimer will result in delays.

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 will not be paid. **Log in to My ASEBP to submit your claims electronically.**

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

ASEBP Claims
PO BOX 4953
SOUTH EDMONTON CRO
EDMONTON AB T6E 5G8

This address is for paper claim submission only. It is different than our standard mailing address.
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.

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ATTACH RECEIPT(S) SECURELY IN THE SPACE PROVIDED BELOW