



Drug Claim Form

- Read instructions before completing this form.
- Use this form for all drug expenses, for dental claims use the Dental Claim form, for extended medical care use the Extended Medical Care Claim form.
- Attach original receipts, photocopies will only be accepted for Co-ordination of benefits along with an Explanation of Benefits from your other drug carrier.
- Sign and mail your claim to the address at the bottom of the form.
- All claims must be received by Assumption Life no later than 12 months after the date of service or purchase.
- **New!** Visit www.healthplan.sfu.ca to learn how to track your claims online and receive your reimbursements by direct deposit.

A Information about you

Please be sure to fully complete this section using block letters. Use your uOttawa student number as your certificate number. Please be sure to write your full name, civic address, and a phone number where you can be reached.

Group # 1480	Certificate # O I T T	Employer, Union, or School Name SFUO
First Name	Last Name	Preferred Language English <input type="checkbox"/> French <input type="checkbox"/>
Home Address, Apt#	City	Province
Home Phone #		Postal Code
Work Phone #		

B Information about your claim

Please indicate if this claim is a Co-ordination of Benefits: Yes No

List the initials of all claimants. Patient's code describes your relationship to the patient: 00 for you, 01 for your spouse, 02 for your child. Submitted amount is the amount claimed for each prescription.

Patient's Initials	Patient's Code	Date of Birth dd / mm / yy	Drug Identification #	Quantity	Prescription #	Dispense Date dd / mm / yy	Dispensing Fee \$	Submitted Amount \$	Office Use Only
							\$	\$	
							\$	\$	
							\$	\$	
							\$	\$	
							\$	\$	

C Authorizing Signature

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Policy Holder's Signature: _____ Date: _____

D Mailing Instructions - mail your claim with original receipts to the nearest ClaimSecure branch.

Claim Secure
P.O. box 6500, Stn. A
Sudbury, Ontario, P3A 5N5

OR

Claim Secure
P.O. Box 1678, Main Post Office
Edmonton, Alberta, T5J 2N9

