DRUG AND EXTENDED HEALTH CARE REIMBURSEMENT CLAIM FORM

Send completed forms with receipts to
Local 493 Benefit Services at:
584 Clinton Ave.
Sudbury ON P3B 2T2
fax:705-674-6728
email:benefits493@liunalocal493.ca

SECTION 1

BENEFIT PLAN AND PLAN MEMBER INFORMATION

You can obtain your Plan/Group No. and your Certificate No. from your NexgenRX Benefits Card

Group Contract No.	Certificate No.	Plan Sponsor / Employer
3037		Local Welfare Trust Fund
Plan Member / Employee name (First, Middle Initial, Last)		Birth date (mm/dd/yyyy)
Address		City / Town
Province ON		Postal Code

Are these expenses eligible for coverage under workers' compensation ◯YES ◯NO

Are you and/or your spouse/dependent(s) covered under any other benefit plan for the expenses being claimed? ◯YES ◯NO

If "Yes", please retain copies of all receipts submitted with this claim for submission to your secondary carrier.
If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mm/yyyy)	Name of spouse's benefit plan administrator	Spouse's plan/group no.	Spouse's certificate no.

SECTION 2

PATIENT INFORMATION

Complete for all expenses
Use one line per each plan beneficiary for whom are claimed.

Patient's Name	**Date of Birth** (dd/mm/yyyy)	**Relationship to Plan Member**	**School and City (complete if patient is a covered student)**

SECTION 3

DRUG EXPENSES

- Attach your **original drug receipts** to the back of this form.
- Each receipt must contain drug identification number (DIN) and the name of the drug.
- You are not required to list this information on this form.

DRUG AND EXTENDED HEALTH CARE REIMBURSEMENT CLAIM FORM

Send completed forms with receipts to
Local 493 Benefit Services at:
584 Clinton Ave., Sudbury ON P3B 2T2
fax:705-674-6728
email:benefits493@liunalocal493.ca

SECTION 4
PARAMEDICAL PRACTITIONER EXPENSES

For paramedical practitioner expenses please attach an **itemized statement** and /or receipt from the practitioner stating all of the below:

- patient name
- name of practitioner
- type of practitioner
- date of service
- length of visit
- charge for treatment
- date last paid by provincial plan (if applicable)
- license and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt. Did a physician refer the patient*? ◯YES ◯NO
**Physician referral required for Massage Therapy only.*

SECTION 5
EQUIPMENT AND APPLIANCE EXPENSES

For equipment and appliance expenses a written recommendation is required from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment
Duration equipment is required. From (dd/mm/yyyy) To (dd/mm/yyyy)

Have you returned your rental equipment? ◯YES ◯NO

SECTION 6
VISION CARE EXPENSES

For **eye exams and prescription eyeglasses**, please attach receipt.
For **contact lenses** attach receipt and have supplier complete and sign below.

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ◯YES ◯NO

Can visual activity be improved by at least 2 lines on the Snellen? ◯YES ◯NO

Chart over the best possible vision with glasses? ◯YES ◯NO

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯YES ◯NO

SIGNATURE OF SUPPLIER	DATE SIGNED (DD/MM/YYYY)

SECTION 7
CLAIMS CONFORMATION NOTE – ORIGINAL RECEIPTS must be attached for all expenses

By signing below, you certify that all the claims referred to in this form are genuine and that the information provided is true and complete and if any such claim concerns your spouse or any dependent that you have their consent to disclose their personal information to us for purpose referred to above. You also authorize us to obtain and exchange information with respect to this claim with any person having such relevant information including any health care provider, insurer, claims adjudicator or administrator or any privately or publicly funded benefit plan or program.

Total Amount Claimed $

SIGNATURE OF PLAN MEMBER	DATE SIGNED (dd/mm/yyyy)

At NexgenRX, we know the importance you attach to maintaining your privacy and the confidentiality of personal information. All such personal information concerning yourself and your spouse and dependants (if any) will be collected, used and disclosed by NexgenRx. This information is only for the purposes of adjudicating claims made by or on behalf such persons and administering the benefit plan under which such claims are made, and for certain ancillary purposes, all as set out in the NexgenRx Privacy Policy published on our website at www.nexgenrx.com. You may obtain a printed copy of such Privacy Policy by writing to us at 145 The West Mall, PO Box 110 U, Toronto, Ontario M8Z 5M4, to the attention of our Chief Privacy Officer. Your claim and your coverage may be denied or terminated if you provide false, incomplete, or misleading information, and we may share information with your plan sponsor without further notification to you. Any monies or overpayments that you may owe in accordance with the provisions of the Group Benefits plan must be repaid. NexgenRx may deduct such monies from your future claim payments or purse such other lawful remedies as we deem necessary.