

# Health claim form

**Submit via mail:** 1403 Kenaston Blvd., Winnipeg MB R3P 2T5

**Submit via fax:** 204-488-6008

**Claim inquiries:** 1-866-586-1010 - claims@mystudentplan.ca

This is a:  Claim or  Predetermination

The personal information we collect from you is kept in strict confidence and will be used only to assess your claim. Please refer to your benefits card for your Group # and Certificate #. For help completing this form, please review the included instructions.

## Plan member information

Name: \_\_\_\_\_ Date of birth (DD/MMM/YYYY): \_\_\_\_\_

Email address: \_\_\_\_\_

Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_

## Coordination of benefits

Are you or your dependants entitled to benefits under any other plan?  Yes  No  
If yes, please provide the second payor information:

Plan member name: \_\_\_\_\_ Date of birth (DD/MMM/YYYY): \_\_\_\_\_

Insurance company: \_\_\_\_\_

Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Coverage effective date: (DD/MMM/YYYY) \_\_\_\_\_

## Claimed expenses

Are any of the claimed services required as a result of an accident?  Yes  No  
Are you seeking damages from a third party?  Yes  No

If yes, please attach details. \_\_\_\_\_

If benefits are to be assigned to a specific provider, please include a letter of assignment from the provider along with the plan member's original signature.

Pay balance using my Health Care Spending Account (HCSA)  
if eligible and subject to sufficient HCSA balance?  Yes  No

Note: Please ensure that these expenses have been submitted for reimbursement to all insurance plans under which these expenses may be eligible prior to submitting for reimbursement under your HCSA.

**Claim details**

Patient name	Date of birth (DD/MMM/YYYY)	Relation to plan member
Service type	Service date (DD/MMM/YYYY)	Amount

Patient name	Date of birth (DD/MMM/YYYY)	Relation to plan member
Service type	Service date (DD/MMM/YYYY)	Amount

Patient name	Date of birth (DD/MMM/YYYY)	Relation to plan member
Service type	Service date (DD/MMM/YYYY)	Amount

I certify that I and/or my dependants incurred these expenses and that the information given is true, correct, and complete to the best of my knowledge and that the attached receipts represent a claim for services. I authorize People Corporation, health care providers, insurance companies, administrators of benefit plans, and service providers to exchange personal information, as necessary, for the adjudication of the claims I submit and the administration of this benefit plan. A photocopy of this is as valid as the original. If I submit a copy of this claim document, I will retain all original receipts and documents for three years from the date of submission. I understand that People Corporation has the right to request these original receipts and audit this claim submission any time within the three years and may request reimbursement if it is found that any documentation is not complete, or if the submission was inaccurate.

\_\_\_\_\_  
Plan Member Signature

\_\_\_\_\_  
Date (DD/MMM/YYYY)

## Instructions

Please submit predetermination requests separate from incurred claims.

If submitting a paper claim form, you must include all original receipts. Keep a copy of the receipts for your records, as People Corporation will not return them. Photocopies of receipts are acceptable only if one of the following situations applies:

- If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.
- If both you and your spouse have health coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. (For example: If your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first.)
- If you have submitted your original receipt to your other insurance company, please provide the following:
  - Photocopies of all invoices and paid-in-full receipts
  - The original statement from the other insurance company

If submitting a fax, you must provide copies of all receipts and can keep the originals for your files. Keep the original documentation for a minimum of three years as People Corporation reserves the right to audit all claims for up to three years from the date of submission. If you have submitted your receipts to another insurance company first, you must provide:

- Photocopies of all invoices and paid-in-full receipts
- The statement from the other insurance company

**Please note that claim submission by email will not be accepted.**

All claims must be submitted with itemized statements and receipts, and must include:

- The claimant's first and last name
- A description of item purchased or service provided
- The date of each purchase or service
- The amount charged for each purchase or service
- The name, address, and phone number of supplier/provider

Claims must be received in our office before the claiming deadline outlined in your benefit booklet in the General Provisions section.

An Explanation of Benefits (EOB) statement indicating how the claim was assessed will be posted to the People Corporation Claims Portal. For plan members who haven't registered for the People Corporation Claims Portal, they'll receive an EOB statement via mail. The EOB is the only document that will be issued regarding the adjudication of the claim. If copies of EOBs are requested, an additional charge may be applied. Eligible claims will be paid by cheque or by direct deposit. Payment can be made to a provider if the payment was assigned.

In order to authorize and request the direct deposit of claim payments, you must:

- Register for direct deposit through our web portal or application, OR
- complete and submit a request for automated claim reimbursement form which can be found at [mystudentplan.ca](http://mystudentplan.ca) or on the People Corporation plan member site (if applicable).

Hospital claims must be submitted on a hospital claim form available from the hospital that provided the services. If expenses are due to a medical emergency while you were outside of the province where you live, please contact People Corporation for support with submitting an Emergency Medical Travel Coverage claim.

There are services that may require the submission of additional information in order for the claim to be adjudicated. Please refer to your plan member booklet for your specific plan requirements. To avoid delays in processing your claim, please ensure all sections of the claim form are completed.

For help completing this form or for more information about your plan, call us at 1-866-586-1010.