Suite 700 Weber Centre
5555 Calgary Trail
Edmonton | Alberta | T6H 5P9
Phone: 1-877-431-4786
www.asebp.ab.ca

EXTENDED HEALTH CARE and VISION CARE CLAIM

Claims that are faxed, unsigned or do not have original receipts attached will be returned

Please answer all questions to support timely processing of your claim (see back for specific instructions). *If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy statement at www.asebp.ab.ca/privacy.html, or contact the Privacy Officer at 780-431-4786.*

Sections marked with an asterisk (*) are mandatory and must be completed in order to process your claim.

COVERED MEMBER'S INFORMATION* *(Please print)*

Covered member's (employee's) name: ______________________________

Mailing address: ______________________________

____

GROUP					SECTION		MEMBER'S ASEBP ID NO.						
1	9	9	3	0									

Postal code: ______________ Phone number: ______________

CLAIM DETAILS* *(Attach original receipts/invoices OR the Explanation of Benefits (EOB) with a copy of the original receipts/invoices)*

PATIENT'S NAME	ASEBP ID NO.	BIRTH DATE (YYYY/MM/DD)	SERVICE DESCRIPTION OR PRESCRIPTION NUMBER	DATE OF SERVICE (YYYY/MM/DD)	CLAIM AMOUNT	RECEIPT ATTACHED?
1.					$	☐ YES
2.					$	☐ YES
3.					$	☐ YES
4.					$	☐ YES
5.					$	☐ YES
6.					$	☐ YES
7.					$	☐ YES
8.					$	☐ YES
9.					$	☐ YES
10.					$	☐ YES

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: ______________________________

☐ Dental ☐ Vision ☐ EHC/Prescription

Effective date of other coverage (YYYY/MM/DD): _____ / _____ / _____

Birth date (YYYY/MM/DD): _____ / _____ / _____

ASSIGNMENT OF BENEFITS: *(To pay the service provider directly)*

I hereby assign benefits payable for this claim to

____
(Service Provider Name)

and authorize payment directly to him/her/them.

Address:

____

____

Covered member's signature:

____

Even if you assign payment to your provider, you are still required to sign and date the consent section of this form.

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 the benefit plan. By submitting this claim form, I am requesting payment for the listed expenses based on benefit plan guidelines.

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:** ______________

CLAIM SUBMISSION REQUIREMENTS

FAXED 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, unsigned or do not 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 dependant).
- **Original receipts/invoices/statements must be attached and indicate:**

  1) - first and last name of individual receiving the service
     - date or dates 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) 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 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 Explanation of Benefits for income tax purposes as no other statement will be issued.
- Some products, many of which fall under the Medical Aids and Equipment category, require additional supporting documentation or pre-approval to facilitate claims processing. Examples include, but are not limited to wigs, bandages and dressings, and joint injectable materials (e.g. Synvisc). Please refer to the applicable section of the Extended Health Care online guide (found under the Benefits and Services tab) on ASEBP's website, www.asebp.ab.ca, for claim requirements for the specific medical service or supply for which you are submitting a claim.

ASSIGNMENT OF BENEFITS

ASEBP has the right to choose which practitioners they will accept assignment of benefit arrangements from and the benefit categories for which assignment of benefit arrangements can be made.

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. **Faxed claims are not accepted.**

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

Alberta School Employee Benefit Plan
Suite 700 Weber Centre
5555 Calgary Trail
Edmonton AB T6H 5P9

Upon receipt in our office, routine claims are processed within 5 - 7 business days.

Suite 700 Weber Centre
5555 Calgary Trail
Edmonton Alberta | T6H 5P9
Phone 1-877 431-4786
www.asebp.ab.ca

DENTAL CARE CLAIM

Policy # 19930

PART 1 DENTIST

Unique No. | Spec | Patient's Office Account No.

I, the covered member of the Alberta School Employee Benefit Plan, hereby assign benefits payable for this claim to the named dentist and authorize payment directly to him/her/them.

Covered member's signature

Patient's name

Mailing address

Postal code: ____________ Phone no.: ____________

Dentist's information

Phone no. ____________

FOR DENTIST USE ONLY: Additional information, diagnosis, procedures or special consideration

Duplicate form ☐

I acknowledge that the total fee of $ ____________ is accurate and has been charged to me for services rendered.

Patient signature (Parent/Guardian)

Office verification

Date of service			Procedure code	Tooth code	Tooth surfaces	Dentist fee	Laboratory charges	Total charges
Day	Mo.	Yr.						

This is an accurate statement of services performed and the total fee due and payable.

TOTAL FEE SUBMITTED

DENTAL ACCIDENT ONLY

Is treatment required as a result of an accident?

☐ NO ☐ YES If yes, please complete the following:

Date of accident: ____________

Teeth injured: ____________

Details of accident: ____________

PART 2 EMPLOYEE STATEMENT *(See back for specific instructions)*

1. Employer ____________
2. Employee name: ____________ ID #: ____________

   Employee address: ____________ Employee's date of birth: YYYY ______ MM ______ DD ______
3. Patient's name: ____________ Relationship to employee: ____________

   Patient's date of birth: YYYY ______ MM ______ DD ______
4. For crown, bridge or dentures: Is this an initial placement? ☐ NO ☐ YES

   If no, indicate date of insertion of existing crown, bridge or denture. YYYY ______ MM ______ DD ______
5. Is treatment required for orthodontic purposes? ☐ NO ☐ YES

COORDINATION OF BENEFITS

Are you and/or your spouse/partner covered under another insurance plan? ☐ NO ☐ YES Is your child covered under another insurance plan? ☐ NO ☐ YES

If yes, ☐ ASEBP Plan ID # ____________ Spouse/partner or child's date of birth: YYYY ______ MM ______ DD ______

OR ☐ Name of other insurance company: ____________ Policy # ____________ ID# ____________

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The personal information contained in this form and supporting documentation as well as other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility of this benefit, verify, assess and pay claims and administer your group benefit plan. By submitting this claim form, I am requesting payment for the listed expenses based on my group benefits plan guidelines and that these expenses may not be covered or may exceed my plan benefits and understand that I am financially responsible to my dentist for the entire treatment.

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 and my dependants' 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

Date: ____________ Signature: ____________

Please turn over ☞

DENTAL CARE CLAIM ***FAXED CLAIMS ARE NOT ACCEPTED***

The reimbursement is applied to the lesser of the actual cost of the expense or the applicable maximum fee level of the current *ASEBP Dental Benefit List.*

PLAN DESCRIPTION

Plan 1	Provides 100% reimbursement of basic treatment to a maximum benefit of $1,500 per person per calendar year.
Plan 2	Provides 100% reimbursement of basic treatment and 50% reimbursement of major treatment to a combined maximum benefit of $2,500 per person per calendar year.
Plan 3	Provides 100% reimbursement of basic treatment and 60% reimbursement of major treatment. The maximum for major treatments is $2,500 per person per calendar year. Provides 60% reimbursement of orthodontic treatment to a lifetime maximum of $3,000.
Plan 4	Provides 50% reimbursement of basic treatment and 50% of major treatment to a combined maximum benefit of $1,000 per person per calendar year. There is an annual family deductible of $50.

Dental Estimates:
(Predetermination)

For all claims with the exception of orthodontics:
A dental estimate is not required for claim payment under the Alberta School Employee Benefit Plan (ASEBP). It will be supplied to you if your dentist submits the request using one of the following methods:

- A paper request where the proposed dental treatment plans are **over** $500
- An electronic request where the proposed dental treatment plans are **under** $500

For orthodontics claims:
ASEBP requires the submission of a predetermination after your initial examination and diagnostics for orthodontics prior to treatment.

X-rays must accompany claims for major services on anterior teeth.

To ensure that 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.

1. Have your dentist complete the statement in Part 1
2. Covered member must complete the statement on Part 2

Note: i) A separate form is required for each person for whom a claim is being made
ii) Additional forms are available from your employer or ASEBP's website (www.asebp.ab.ca)
iii) The form must be signed by the covered member

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