



Health Claim Form

Please Make Payment to:

Provider Cardholder

Please Return Completed Forms Along with Receipts to:

Head Office	200 Quikcard Centre 17010 103 Avenue Edmonton AB T5S 1K7	p 780.426.7526 f 780.424.7669 1.800.232.1997	Atlantic Canada	201 1600 Bedford Highway Bedford, NS B4A 1E8	p 902.492.2111 f 902.492.2112 1.888.846.4484 quikcard.com
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Cardholder Information

Group# _____ Card# _____

Surname _____

Given Name _____

Date of Birth _____

Address _____

City _____

Province _____ Postal Code _____

Patient Information (if not the cardholder)

Name _____

Date of Birth _____

Coordination of Benefits - Are any of these health benefits or services covered by any other Insurance, Workers Compensation or Government Plan? Yes No

If yes - Is the member under the other plan you or your spouse?
 You Spouse

If Spouse

Spouse's Name _____

Spouse's Date of Birth _____

Name of other Plan Provider _____

Policy# _____ Certificate# _____

Provider Information*

(Required only if the payment is to the Provider)

Signature

Confirmation# _____

Name _____

Type of Practitioner _____

License# _____

Address _____

City _____

Province _____ Postal Code _____

*Must be Registered to receive payment directly from Quikcard. Visit www.quikcard.com for more information.

Cardholder Information – Please complete a separate form for each patient

Date of Service/Purchase	Nature of Expense	Provider Name	Prescribing Physician	Amount Claimed

HSA Authorization

HSA Information:

By checking the box next to a claimed item, I authorize any portion of the claimed item not paid by my health plan to be reimbursed from my Health Spending Account.

Signature

Statement & Authorization

CLAIMANT'S STATEMENT: I declare that the above statements are true and complete to the best of my knowledge and belief. I am authorized to provide and receive the personal information of my spouse and dependants to submit this claim and for benefit administration purposes and to give the authorization set out below on my own and any of their behalf.

PRIVACY NOTICE: The information requested in respect of this claim is required by Quikcard for benefit administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information consult Quikcard's privacy policy at www.Quikcard/privacy or contact Quikcard by phone or mail.

AUTHORIZATION: I authorize for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care provider, hospital, health care institution, and any other medical or

medically related facility, any insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Quikcard, all personal health information or any other information or records in its possession that is requested while and for the purpose of administering this claim. A photocopy of this authorization shall be as valid as the original.

Signature of Cardholder

Date