Quikcard

V2023112920

CLAIM FORM – For Vision, Health, and Drug

INSTRUCTIONS: Attach detailed receipts for all expenses, sign, and date form.	**IMPORTANT:** This claim form will be returned if incomplete or unsigned.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to claims@quikcard.com.

Please make payment to: ☐ Provider ☐ Cardholder

1. Cardholder Information

Name | Group # | Certificate # | Date of Birth D/M/Y

Address | City | Province | Postal Code

2. Patient Information *(if not the cardholder)*

Name | Date of Birth D/M/Y | ☐ Spouse | ☐ Dependent

3. Provider Information *(Required only if the payment is to the Provider*)*

Name | Type of Practitioner | License #

Address | City | Province | Postal Code

Signature of Office Designate | Date | Quikcard Confirmation #

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

4. Coordination of Benefits

Was this treatment covered by any other plan? ☐ Yes ☐ No

If yes, name of the other insurer

***Please provide a copy of their payment statement**

5. Claim Details *(Please keep a copy of this form and receipts for your records)*

Date of Service	Nature of Expense	Fee Amount

If additional space is needed, attach a separate page to this claim form

Credit card receipts and or debit slips alone are insufficient. All receipts must include:

Vision and Health

- Patient name
- Date of Service
- Name of treatment provided
- Charge for each service
- Provider's name and professional designation

Drug

- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

6. Disclaimers

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

SERVICES MEDICALLY REQUIRED: I declare that the health services claimed on this form are medically required and not of a cosmetic nature.

PRODUCTS OR SERVICES RECEIVED: I declare that the products or services listed on this claim have been received in full.

CLAIMANT'S STATEMENT: I declare that the information contained on this claim form is 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 benefits administration purposes and to give the authorization set out below on my own and any of their behalf.

_____ _____

Signature of Cardholder Date