SACB-HDP

HEALTH CLAIM FORM – Contract: 165069

SECTION 1 – Member Information (*Student*) معلومات المبتعث

Member Name (*Last Name, First Name*):		**Certificate Number:**	
Address:		**Apt.:**	
		Telephone Number:	
City:		**Province:** QC	**Postal Code:**

SECTION 2 – Patient Information معلومات المريض

Patient Name (*Last Name, First Name*):			**Date of Birth (*dd/mm/yyyy*):**	
Relationship to Member:	**Self**	**Spouse**	**Dependent Child**	**Accompanying Person**
	☑	❑	❑	❑

SECTION 3 – Authorization (To be completed by member) تفويض (يتم إكمالها من قبل المبتعث)

The member must sign section "A" **الإمضاء على القسم "A"**

A) Certification: I, the undersigned, certify that the information I am submitting to the Cigna Life Insurance Company of Canada ("Cigna") in suppor't of my claim, is true and complete, to the best of my knowledge and belief. I understand that Cigna may investigate my claim by collecting additional relevant personal information from me and if required, from third parties.

Authorization: I authorize, for a period of not less than twelve (12) and not more than twenty-four (24) months from the date hereof, any employer, physician,practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Cigna, or its representatives, all medical or benefit payment information or any other information or records in its possession that Cigna may hold or request while administering this claim. I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____ **Member** signature _____

If the payment is to be made to the provider, please also sign section "B" **إذا كان الدفع مباشرة الى مقدم الخدمة, الرجاء الإمضاء على القسم "B" ايضاً**

B) I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Date: _____ **Member** signature: _____

SECTION 4 – Provider Information (*To be completed by provider*) معلومات مقدم الخدمة

Provider Name:									**Specialty:**
Address:									**Postal Code:**
Provider I.D. Number:									**Telephone Number:**

SECTION 5 – Statement of Services (*To be completed by provider*) معلومات عن الخدمات الطبية

Service Date	Description of Service	Provincial Code (plus time units, if applicable)	Charge	Diagnosis

I declare that the above is a correct statement of services rendered.

Date: _____ **Provider's Signature:** _____

Note: *__Physicians__ and __Hospitals__ must provide the diagnosis
*__Dentists__: a Standard Claim Form is preferred, complete with codes for services rendered.

DIRECT ALL CLAIMS AND INQUIRIES TO:
SACB-HDP Claims Administrator
700-1420 Blair Place
Ottawa (ON) K1J 9L8
Email: clients@sacb-hdp.com
Tel.: 1-888-663-6623 Fax: 613-741-7771