EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS

Part 1 – EMPLOYEE INFORMATION - This section MUST be completed in full by the employee.

Employer Name: _____

Employee Name: _____

Employee Address: _____
Box. No./Apt No. Number and Street

_____ _____ _____
City or Town Province Postal Code

Please submit completed form to:

TELUS Health Solutions
Claims Payment Department
630 Rene-Levesque Blvd. West
Suite 2200
Montreal, Quebec H3B 1S6

EMPLOYEE I.D. NO FROM YOUR ASSURE CARD ☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐

(Please DO NOT submit until all numbers can be reported)

Is this claim an adjustment to a previously paid claim? Yes: ☐ No: ☐

If yes, please have your Benefit Administrator authorize: _____

Part 2 – CLAIMANT INFORMATION – This section must list **all** claimant information.

IMPORTANT – Original Pharmacy receipts **MUST** be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee=01; Spouse =02; Dependent Child=03; Overage Student=04; Disabled Dependent=05

Part 3 – OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of school: _____

Address of school: _____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 – CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Worker's Compensation Board or Government Plan?

Yes: ☐ No: ☐

If yes, please advise us of the name of the other insuring agency or plan: _____

Group Policy/Plan No.: _____ Cert./I.D. No.: _____

Spouses day and month of birth: Day: _____ Month: _____

If this claim has been submitted under another plan, you **MUST** attach the original Explanation of Benefits statement from that plan and COPIES of the receipts.

Part 5 – OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made? _____

What is the currency of this country? _____

I hereby certify that the above information is complete and accurate and that all of the expenses were for services and supplies received by me and/or my eligible dependents. I authorize the release of information relating to the expenses on this form.

EMPLOYEE SIGNATURE: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU. PLEASE KEEP A COPY FOR YOUR RECORDS. **ALL INQUIRIES MUST BE MADE THROUGH YOUR EMPLOYEE BENEFIT OFFICE OR INSURANCE COMPANY**.