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**.