OTIP Health Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

1.866.783.6847
www.otipservices.com

Extended Health Benefit Claim Form

IMPORTANT: To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.)
Please retain copies for your files as original receipts will not be returned.

PLAN MEMBER INFORMATION (Please Print)

Plan Number	Identification Number	Plan Name

Plan Member Name (First, Middle Initial and Last)	Date of Birth *(mm/dd/yyyy)*

Address (Number, Street and Apt.)	City/Town	Province	Postal Code

1. Is this a Workplace Safety and Insurance Board case (WSIB)? ☐ Yes ☐ No
2. Is your claim a result of an accident? ☐ Yes ☐ No

If answer is "Yes" to Question 1 or 2 above, give explanation, including a brief description of illness or injury and where and when injury occurred:

Are you, your spouse or dependants covered under any other plan for the expenses being claimed? ☐ Yes ☐ No

If "Yes", please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier.
If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth *(mm/dd/yyyy)*: _____ Name of spouse's insurance company: _____

Spouse's plan number: _____ Spouse's identification number: _____

PATIENT INFORMATION (Complete for all expenses. Use one line per patient.)

PATIENT'S NAME	DATE OF BIRTH *(mm/dd/yyyy)* (1st Claim Only)	RELATIONSHIP TO PLAN MEMBER (1st Claim Only)	Complete if patient is a student 21 or older	
			SCHOOL AND CITY	If employed, hrs worked per week

PRESCRIPTION DRUG EXPENSES

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the Drug Identification Number (D.I.N.), the name of the prescription drug and the quantity.
- You are not required to list this information on this form.

PRACTITIONER'S/PARAMEDICAL EXPENSES (e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses, please attach an **itemized statement** and/or receipt stating:

- patient name
- name of practitioner
- type of practitioner
- date of service
- length of visit
- charge for treatment
- date last paid by provincial plan (if applicable), and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

PLEASE COMPLETE REVERSE

EQUIPMENT AND APPLIANCE EXPENSES

For equipment and appliance expenses, OTIP requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item: _____

_____

_____

Duration equipment is required: From _____ To _____

Date *(mm/dd/yyyy)* Date *(mm/dd/yyyy)*

Has rental equipment been returned? ☐ Yes ☐ No

VISION CARE EXPENSES

Please enclose an itemized receipt indicating: patient's name, cost of contact lenses, cost of glasses, dispensing fee, cost of eye exam, date of eye exam, cost of tinting, treatment, and date dispensed.

Medically necessary contact lenses

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia?	☐ Yes	☐ No
Can visual acuity be improved at least 2 lines on the Snellen chart over the best possible vision with glasses?	☐ Yes	☐ No
Could visual acuity be improved up to the 20/40 level by glasses?	☐ Yes	☐ No

CLAIMS CONFIRMATION

NOTE - ORIGINAL RECEIPTS MUST BE ATTACHED FOR ALL EXPENSES.

Total amount of ALL receipts submitted $ _____

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** OTIP and its insurer to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, its insurer and their reinsurers and/or service providers, for the Purposes. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that OTIP's Privacy Policy is available at www.otipservices.com or by request.

_____ _____

Signature of Plan Member Date *(mm/dd/yyyy)*

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, OTIP's representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

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QUESTIONS

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