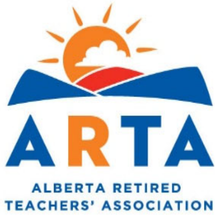

ARTA RETIREE BENEFITS PLAN
c/o ASEBP
Allendale Centre East
Suite 301, 6104-104 Street NW
EDMONTON AB T6H 2K7
780-989-8709 (Edmonton) Toll-free: 1-855-444-2782
Email: arta@asebp.ca

EXTENDED HEALTH CARE AND VISION CARE CLAIM FORM

FAXED CLAIMS NOT ACCEPTED

Please answer all questions to support timely processing of your claim (see back for specific instructions).

PLAN MEMBER'S INFORMATION *(PLEASE PRINT)*

Plan member's name: ____

Mailing address: ____

____

____

GROUP					SECTION			ARTA BENEFITS ID NO.						
1	9	9	3	0	A			4						

Is this claim due to an out-of-province emergency?
☐ Yes ☐ No

Postal code: ____________________ Phone number: ____________________

CLAIM DETAILS *(Attach **original** receipts/invoices **OR** the Explanation of Benefits (EOB) with a copy of the original receipts/invoices)*

PATIENT'S NAME	ARTA BENEFITS ID NO.	BIRTH DATE (YYYY/MM/DD)	SERVICE DESCRIPTION OR PRESCRIPTION NUMBER	DATE OF SERVICE (YYYY/MM/DD)	D.I.N. (Prescriptions only)	CLAIM AMOUNT
1.						$
2.						$
3.						$
4.						$
5.						$

COORDINATION OF BENEFITS

If you or your dependants have health benefit coverage through another health benefits company or insurance company, please complete below. *If you claimed through the health benefit plan listed below first, please attach the EOB to this claim form.*

Name of other health benefits company or insurance company:

____

Name of person holding coverage: ______________________________

☐ Dental ☐ Vision ☐ EHC/Prescription

Effective date of other coverage (YYYY/MM/DD): _____ / _____ / _____

Birth date (YYYY/MM/DD): _____ / _____ / _____

ASSIGNMENT OF BENEFITS: *(To pay the service provider directly)*

I hereby assign benefits payable for this claim to

____
(Service Provider Name)

and authorize payment directly to him/her/them.

Address:

____

____

Plan member's signature:

____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I understand that the personal information contained in this claim form (with supporting documentation) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, verify, assess and pay claims and administer my benefit plan. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.

Plan member/partner's signature: ______________________________ Date: ______________________________

CLAIM SUBMISSION REQUIREMENTS ***FAXED CLAIMS ARE NOT ACCEPTED***

To ensure your claim is processed promptly, please read the following instructions. Your claim may be returned if any of the required information is missing or incomplete.

- **Original receipts/invoices/statements must be attached and indicate:**
  1) - first and last name of individual receiving the service
     - date or dates on which service was provided
     - total cost of the service
     - provider's name, address, phone number

  OR

  2) if you claimed through another health benefit plan first, attach the Explanation of Benefits (EOB) to this claim form with a copy of the original receipt, invoice or statement

  Note: Credit/debit card and cash register receipts **are not** acceptable nor are photocopied receipts or faxed claims.

- **All original receipts will be retained by ARTA's plan administrator, the Alberta School Employee Benefit Plan (ASEBP), and will not be returned to you**. Please photocopy your receipts if you require them for your records or for coordination of benefits with another benefit provider.
- Upon receipt of your payment, please retain the EOB for income tax purposes.

In addition:

a) Vision Care claims require you to attach the original detailed receipt (no prescription required).

b) Prescription medicine claims must include the drug identification number (DIN) on the receipt (except for out-of-country prescriptions).

c) Ambulance service claims must have an original invoice showing the date of service, point of origin, and destination. For more information on ambulance billing, please refer to the EHC Plan Text which can be found on ARTA's website, www.arta.net, under Benefits Programs, Plan Text Documents/Contracts.

d) Claims requiring pre-approval, such as:

- Private duty nursing and home care
- CoaguChek monitor and test strips
- Positioning equipment following vitrectomy surgery
- Lenses required from surgery

Must include:

- A health care provider's letter indicating diagnosis, which medical services are required, and how long they will be needed.
- A letter indicating you:
  - are not eligible for coverage under any government programs; or
  - have reached your maximum coverage under the government program.
- An original receipt/invoice including an itemized breakdown of charges.

e) Psychology service claims require:

- An original receipt/invoice indicating:
  - the length of each session;
  - the amount being charged for each session; and
  - the name of each patient attending.

f) Massage therapy claims must have the providers' name, association name, mailing address and registration number on the receipt.

g) Accidental dental claims require a completed *Dental Care Claim* form clearly identifying all injured teeth, the date of the accident, and an explanation of how the accident happened. Please make sure to write **"dental accident"** across the top of the first claim form you submit.

CLAIM SUBMISSION DEADLINE

Claims must be received by ARTA's plan administrator, ASEBP, before the end of the calendar year following the year the expense is incurred. For example, claims incurred in 2016 must be received before December 31, 2017. Claims received outside this period will not be paid.

Please mail your completed *Extended Health Care and Vision Care Claim* form with original receipts/invoices firmly attached, to:

ARTA Retiree Benefits Plan
c/o ASEBP
Allendale Centre East
Suite 301, 6104-104 Street NW
EDMONTON AB T6H 2K7

Sponsored by:

ARTA Retiree Benefits Plan administered by: