

## EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS

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

Employer Name:				Please submit completed form to:					
Employee Name:	TELUS Health Solutions								
Employee Address:	Claims Payment Department								
Box. No./Apt No. Number and Street				630 Rene-Levesque Blvd. West Suite 2200 Montreal, Quebec H3B 1S6					
	City or Town	Province	Postal Code						
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; Sp	oouse =02; Dependent C	Child=03; Overage Student=	=04; Disabled Dependent=0	)5

## 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	e 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.