

RBC Insurance

CLAIM FORM FOR RELATED HEALTH **PROFESSIONAL SERVICES**

PROFESSIONAL TYPE CODES * May not be applicable to all plan members of RBC Life

- 1 PODIATRIST
- 2 CHIROPODIST
- 3 CHIROPRACTOR
- 7 NATUROPATH
 - 8 SPEECH THERAPIST/PATHOLOGIST *

6 CLINICAL PSYCHOLOGIST *

- 4 PHYSIOTHERAPIST * 9
- 12 CERTIFIED ATHLETIC THERAPIST *

10 OSTEOPATH

11 DIETICIAN *

- ACUPUNCTURE (PHYSICIAN OR SURGEON)13 SHIATSU THERAPIST * 14 OCCUPATIONAL THERAPIST
- 15 HOMEOPATH
- 16 CHRISTIAN SCIENCE PRACTITIONER
- 17 MUSCLE PHYSIOLOGIST *
- 18 COUNSELLOR
- 19 OTHER Specify

5 REGISTERED MASSAGE THERAPIST *

* PHYSICIAN'S AUTHORIZATION MAY BE REQUIRED ON INITIAL CLAIM FOR PROFESSIONAL TYPE CODES 4, 5, 8, 11, 12, 13, 17

PLEASE NOTE: This claim form cannot be used for supplies of any type, only services or treatments. Please use one form per practitioner, as well as per patient.

PROVIDER							PATIENT			
PROVIDER NO.			PROVIDER	R PHONE	NO.	PLAN MEMB	IBER ID DEP # COMPANY NAME			
NAME OF PRACTITIONER			. ,		DE - Please	SURNAME	FIRST NAME BIRTH DATE			
ADDRESS						ADDRESS				
CITY PROV.				PC	OSTAL CODE	CITY	PROV. POSTAL CODE			
BY SIGNING THIS CLAIM FORM AND/OR SUBMITTING ACTUAL RECEIPTS, I AGREE THAT THE INFORMATION PROVIDED ON THIS FORM IS COMPLETE AND ACCURATE. I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME TO RBC Life ABOUT MYSELF AND MY DEPENDENTS, WILL BE USED BY RBC Life FOR CLAIMS ADJUDICATION AND ANY OTHER SERVICES NECESSARY IN THE ADMINISTRATION OF OUR BENEFITS WHICH MAY INCLUDE THE EXCHANGE OF INFORMATION WITH OTHER PARTIES TO ADMINISTER THIS BENEFIT CLAIM. I AM AUTHORIZED BY MY SPOUSE AND/OR DEPENDENTS TO DISCLOSE AND RECEIVE INFORMATION ABOUT THEM THAT IS USED FOR THESE PURPOSES. I UNDERSTAND THAT THIS INFORMATION MAY BE SEEN BY THE INSURED. CLAIM ONLY FOR THOSE SERVICES RENDERED AFTER PROVINCIAL PLAN MAXIMUM HAS BEEN EXHAUSTED (IF APPLICABLE) DATE OF LAST VISIT COVERED BY PROVINCIAL PLAN YY MO DAY										
	TREATMENT RENDERED # OF HOURS - if applicable)	YY	МО	DAY	TAX INC. Y or N	CHARGES \$	DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES INO			
1.							IF YES, INSURANCE COMPANY NAME			
2.										
3.							IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES D NO D			
4.							IF YES, DATE OF ACCIDENT			
5.							YES D NO			
6.							IF YES, WSIB / WCB CASE #			
7.							I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.			
8.										
9.							SIGNATURE OF PROVIDE		ISTRATION NO., CREDENTIALS & OCIATION	
10.							I CERTIFY THAT THE ABOVE TREATMENTS WERE RENDERED.			
11.							1			
12.							CLAIM HAVE BEEN PAID IN FULL BY THE PLAN MEMBER. PLEASE REIMBURSE PLAN MEMBER DIRECTLY		I CERTIFY THAT THE ABOVE	
13.									TREATMENT WAS RENDERED AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER	
14.									NAMED ABOVE.	
TOTAL							SIGNATURE OF PROVIDE	R	SIGNATURE OF PATIENT	

Patient Diagnosis

THERE IS NO NEED TO ATTACH INVOICES OR RECEIPTS IF THIS FORM IS FULLY COMPLETED BY THE SERVICE PROVIDER

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).

RBC Life Insurance Company

P.O. BOX 1613, WINDSOR, ONTARIO N9A 0B8

ATTENTION: EHS DEPARTMENT

CUSTOMER SERVICE CENTRE 1-855-264-2174