

EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS

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

Employee Name: Employee Address: Box. No	e Name:			e submit completed form to: S Health Solutions s Payment Department ene-Levesque Blvd. West 2200 eal, Quebec H3B 1S6
EMPLOYEE I.D. NO FROM YOUR ASSURE CARD		DO NOT submit until all	numbers can be report	ed)
Is this claim an adjustment to a previous If yes, please have your Benefit Admin				
Part 2 – CLAIMANT INFORMA IMPORTANT – Original Pharmacy rec			ant information.	
Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged
*PATIENT CODE: Employee=01; Spo	ouse =02; Dependent (Child=03; Overage Student:	=04; Disabled Dependent=	05
Part 3 – OVERAGE STUDENT If your policy provides coverage for own Name of school: Address of school: Please contact your Employee Benefit	erage students, please	e complete the following:		
Part 4 – CO-ORDINATION OF Is your spouse covered for these expe Yes: No: If yes, please advise us of the name of Group Policy/Plan No.: Spouses day and month of birth: Day: If this claim has been submitted under the receipts.	the other insuring ago Cert./I.D	ency or plan: . No.:	·	
Part 5 – OUT OF COUNTRY Of this claim is for medication purchase In what country was the purchase made What is the currency of this country?	d outside of Canada p	_	:	
I hereby certify that the above informat and/or my eligible dependents. I author	•		•	and supplies received by me
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.