



Bigstone Health Benefits

16310 100 Avenue NW
Edmonton, Alberta T5P 4X5

Vision: To revive, strengthen and protect members' treaty rights to health and to enhance the quality of life of members and others living in Bigstone traditional lands.

CLIENT REIMBURSEMENT INSTRUCTIONS

Bigstone Health Benefits encourages you to visit providers who bill Bigstone Health Benefits directly. However, if you choose a provider not enrolled with Bigstone Health Benefits you must pay for the item/service and then submit all required documentation to the Bigstone Health Benefits to be considered for reimbursement. For coverage information, visit the Bigstone Health Commission website or refer to the Bigstone Health Benefits pamphlet. You may call our office beforehand to inquire if the item/service is a covered benefit and if any additional supporting documentation is required. The provider may charge more than the amount Bigstone Health Benefits covers, meaning you may not be reimbursed the full amount paid.

- Claims must be submitted and received by our office within **one year** of the date of service or date of receipt.
- Complete and sign the reimbursement form. Incomplete reimbursement submissions will be returned.
- Complete a separate reimbursement form for each benefit (e.g., dental receipts on one form and pharmacy receipts on another form)
- If reimbursement is being claimed by an individual other than the client, complete the payee section.
- For direct deposit payment, complete the Electronic Funds Transfer form. A cheque will be issued if you do not complete the Electronic Funds Transfer form.

REQUIRED DOCUMENTATION

Pharmacy:

- ✓ Official prescription receipt (receipt provided by Pharmacist) *required for all pharmacy requests including over-the-counter items.
- ✓ If item/service has been partially funded by another coverage, include the detailed statement or explanation of benefits.

Medical Supplies & Equipment:

- ✓ Original receipt as proof of payment
- ✓ Copy of prescription
- ✓ If item/service has been partially funded by another coverage, include the detailed statement or explanation of benefits.
- ✓ Contact Bigstone Health Benefits Medical Supplies Adjudicator to inquire if additional documentation is required.

Vision:

- ✓ Original receipt as proof of payment
- ✓ Copy of optometrist prescription
- ✓ If item/service has been partially funded by another coverage, include the detailed statement or explanation of benefits.

Dental:

- ✓ Original receipt as proof of payment
- ✓ Standard Dental Claim Form
- ✓ If item/service has been partially funded by another coverage, include the detailed statement or explanation of benefits.

Mental Health Counselling:

- ✓ Original receipt as proof of payment
- ✓ If item/service has been partially funded by another coverage, include the detailed statement or explanation of benefits.



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CLIENT REIMBURSEMENT FORM

Refer to page 1 for reimbursement instructions

CLIENT INFORMATION

SURNAME

FIRST NAME

STATUS #

DOB (MM/DD/YYYY)

FULL MAILING ADDRESS

PHONE NUMBER

*If client is under 24 months of age and not registered, provide parent/legal guardian information below.

SURNAME

FIRST NAME

STATUS #

DOB (MM/DD/YYYY)

PAYEE INFORMATION

PAYEE FULL NAME

FULL MAILING ADDRESS

PHONE NUMBER

RELATIONSHIP TO CLIENT

CLAIM INFORMATION

BENEFIT TYPE (SELECT ONE): ☐ PHARMACY

☐ MEDICAL SUPPLIES & EQUIPMENT

☐ VISION

☐ DENTAL

☐ MENTAL HEALTH COUNSELLING

DATE OF SERVICE	ITEM/SERVICE DESCRIPTION	AMOUNT CLAIMED	AMOUNT PAID FOR OFFICE USE ONLY

Client Signature

Date

Submit reimbursement by mail with all required documentation attached to the above address.

FOR OFFICE USE ONLY

Total Amount Authorized: _____

Authorizing Signature

Authorizing Code

Date



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Electronic Funds Transfer

Do not complete, if you prefer payment by cheque.

Client Information

Full Legal Name: _____

Status Number: _____

Mailing Address: _____

Email Address: _____

Phone Number: _____

Banking Information

Bank Name: _____

Institution Number: _____

Transit Number: _____

Account Number: _____

***Include copy of VOID CHEQUE or DIRECT DEPOSIT form, or form will not be accepted**

Submit reimbursement by mail with all required documentation attached to the above address.