BIGSTONE HEALTH BENEFITS PHARMACY MANUAL CLAIM

Resubmission ☐

Client Information

Surname

Client Identification No.

Given Name(s)

Date of Birth

Client Signature: _____

Claim Information

1.

Date of Service | Day Supply | DIN/Item Code | Prescription No.

Quantity | Item Cost | Dispensing Fee | Mark Up | Third Party Share | Amount Claim

2.

Date of Service | Day Supply | DIN/Item Code | Prescription No.

Quantity | Item Cost | Dispensing Fee | Mark Up | Third Party Share | Amount Claim

3.

Date of Service | Day Supply | DIN/Item Code | Prescription No.

Quantity | Item Cost | Dispensing Fee | Mark Up | Third Party Share | Amount Claim

4.

Date of Service | Day Supply | DIN/Item Code | Prescription No.

Quantity | Item Cost | Dispensing Fee | Mark Up | Third Party Share | Amount Claim

Date of Dispense must be after the prior approval date or between the start and end date of the prior approval date

Total:

	Prescriber	License No.	Prior Approval No. if Item requires a P/A no.
1.			
2.			
3.			
4.			

Provider Name and Address

Bigstone Provider No. _____

If the Client is under 24 months of age and is not registered, please provide the parent's information

Surname

Client Identification No.

Given Name(s)

Date of Birth

Forward the completed form along with prescription receipts to:

Bigstone Health Benefits - Pharmacy
16310 100 Avenue NW
Edmonton, AB, T5P 4X5
Or fax to: 780-444-6521

July 2023