

# EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS



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

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_

Box No./Apt. No., Number and Street \_\_\_\_\_

City or Town \_\_\_\_\_

Province \_\_\_\_\_

Postal Code \_\_\_\_\_

**EMPLOYEE I.D. NO  
FROM YOUR ASSURE™  
CARD**





(Please DO NOT submit until all numbers can be reported)

Please submit completed form to:  
Emergis Inc.  
Claims Payment Department  
5090 Explorer Drive, Suite 1000  
Mississauga, Ontario L4W 4X6

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; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

## 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 covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' 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.: \_\_\_\_\_

Spouse's 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 the **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.**