MHCSI
Managed Health Care Services Inc.

Health Services Spending Account Claim Form

Member Information (Please Print)

Group #	ID #	Member Surname	First Name	Employer/Plan Sponsor

Member's Home /Mailing Address (Apt#)	City	Province	Postal Code

Telephone Number : ( )	Work ( )

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth (day/month/year)	Relationship to Plan Member
		Spouse ☐ Daughter ☐ Son ☐ Other ☐ (Describe)
		Spouse ☐ Daughter ☐ Son ☐ Other ☐ (Describe)
		Spouse ☐ Daughter ☐ Son ☐ Other ☐ (Describe)

EXPENSES – (Attach original receipts or previous payor's Explanation of Benefit statement and list below.) *see note

Nature of expense	Date incurred (day/month/year)	Claim Value	Previously Paid	HSSA Claim
		$.	$.	$.
		$.	$.	$.
		$.	$.	$.
		$.	$.	$.
			HSSA Total Claim	**$.**

1. Have any of the health benefits or services being claimed here been submitted to another plan for payment.

☐ Yes ☐ No

***If you are claiming for goods or services that are not covered benefits under another plan, you must answer 'No' in question 1 and provide original receipts.**

***If you are claiming for the unpaid portion for goods or services submitted to another plan, you must answer 'Yes' in question 1 and provide the Explanation of Benefit statement or original receipts indicating the unpaid portion being claimed.**

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I authorize MHCSI, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with MHCSI to exchange necessary information regarding this claim to administer my health benefit plan.

Health Services Spending Account (HSSA) Signature

I wish any portion of my claim not paid by my Extended Health or Dental plan to be reimbursed from my *Health Services Spending Account.*

I hereby certify that the above expenses are considered eligible by Revenue Canada to be payable from a *Health Services Spending Account.*

Signature_____ **Date**_____

All information recorded on this form is confidential. Send all claims and inquiries to:

Managed Health Care Services Inc. (MHCSI)
201 Brownlow Avenue Unit 20 Dartmouth, NS B3B 1W2
1-888-686-6427 (www.mhcsibenefits.ca)

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