Wawanesa Life®

CLAIM FORM FOR RELATED HEALTH PROFESSIONAL SERVICES

PROFESSIONAL TYPE CODES * May not be applicable to all plan members of Wawanesa Life

1	PODIATRIST	**6**	CLINICAL PSYCHOLOGIST *	**10**	OSTEOPATH	**14**	SOCIAL WORKER/FAMILY COUNSELLOR
2	CHIROPODIST	**7**	NATUROPATH	**11**	DIETICIAN *	**15**	OTHER - Specify
3	CHIROPRACTOR	**8**	SPEECH THERAPIST/PATHOLOGIST *	**12**	CERTIFIED ATHLETIC THERAPIST *		
4	PHYSIOTHERAPIST *	**9**	ACUPUNCTURE	**13**	OCCUPATIONAL THERAPIST *		
5	REGISTERED MASSAGE THERAPIST *						

*** PHYSICIAN'S AUTHORIZATION MAY BE REQUIRED ON INITIAL CLAIM FOR PROFESSIONAL TYPE CODES 4, 5, 8, 11, 12**

PLEASE NOTE: This claim form cannot be used for supplies of any type, only services or treatments. Please use one form per practitioner, as well as per patient.

PROVIDER

WAWANESA LIFE PROVIDER NO. OF PRACTITIONER	PROVIDER PHONE NO. ( )
NAME OF PRACTITIONER	PROFESSION TYPE CODE - Please specify (refer to above)
ADDRESS	
CITY / PROV. / POSTAL CODE	

PATIENT

WLI NUMBER	DEP #	COMPANY NAME
SURNAME / FIRST NAME		BIRTH DATE __/__/__ YY MO DAY
ADDRESS		
CITY / PROV. / POSTAL CODE		

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Wawanesa Life about myself and my dependents, will be used by Wawanesa Life for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize Wawanesa Life to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

Claim only for those services rendered after provincial plan maximum has been exhausted (if applicable)
Date of last visit covered by provincial plan ____/____/____ YY MO DAY

	TREATMENT RENDERED # OF HOURS - if applicable)	YY	MO	DAY	TAX INC. Y or N	CHARGES $
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
	TOTAL					

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES ☐ NO ☐

IF YES, INSURANCE COMPANY NAME _____

IF OTHER COVERAGE IS WAWANESA LIFE, INDICATE WAWANESA LIFE NUMBER

_____

IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES ☐ NO ☐

IF YES, DATE OF ACCIDENT _____

IS TREATMENT REQUIRED DUE TO A WORK RELATED INJURY? YES ☐ NO ☐

IF YES, DATE OF INJURY _____

IF YES, WSIB / WCB CASE # _____

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

SIGNATURE OF PROVIDER | **REGISTRATION NO., CREDENTIALS & ASSOCIATION**

I CERTIFY THAT THE ABOVE TREATMENTS WERE RENDERED.

PATIENT SIGNATURE

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PLAN MEMBER. PLEASE REIMBURSE PLAN MEMBER DIRECTLY.	**I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER NAMED ABOVE.**
SIGNATURE OF PROVIDER	**SIGNATURE OF PATIENT**

Patient Diagnosis _____

THERE IS NO NEED TO ATTACH INVOICES OR RECEIPTS IF THIS FORM IS FULLY COMPLETED BY THE SERVICE PROVIDER

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in you benefit plan documentation).

Wawanesa Life
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Attn: Group Benefit Services
Group Customer Service: 1.800.665.7076
Website: wawanesalife.com