MHCSI
Managed Health Care Services Inc.

Health Services Spending Account Claim Form

Member Information (Please Print)

Group #	Certificate #	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)

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**_____

EXPENSES-(Attach original receipts or previous payor's Explanation of Benefit statement and list below.)

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

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan?

☐ Yes ☐ No

2 a. If yes, indicate member under other plan: ☐ Self ☐ Spouse

Name_____ Date of Birth ____/_____/_____
(Day/Month/Year)

2 b. Name of other insuring agency or plan

_____

Policy No. _____

Certificate No. _____

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

Managed Health Care Services Inc. (MHCSI)
535 Portland Street Unit 1, Dartmouth NS B2Y 4B1
1-888-686-6427 (www.mhcsibenefits.ca)