



HEALTH CARE SPENDING ACCOUNT (HCSA) CLAIM AND PAYMENT REQUEST FORM

Use this form to submit expenses to your Health Care Spending Account

- A Health Care Spending Account may be used to claim health or dental related costs incurred by you and/or your dependents. These expenses must meet the Canada Revenue Agency's (CRA) tax deduction guidelines for eligible expenses.
- It is your responsibility to determine if your medical expenses are allowable under the Canada Revenue Agency's rules and guidelines.

1. PLAN MEMBER INFORMATION

Surname		First Name	Alberta Blue Cross ID Number
Address			Group Number 35
City	Province	Postal Code	Telephone Number

2. PLAN CHOICE

The intent of this claim form is to submit expenses **directly** to your HCSA plan. If you would like Alberta Blue Cross to determine if the expenses below could be paid through your health/dental plan **first** before being sent to your HCSA plan, please check the box below:

Please pay eligible amounts through my health/dental plan first.

3. CLAIM SUBMISSION DETAILS: (Remember to attach supporting receipts and/or statements from other benefits carriers.)

Expense Description	Date of Service (YY / MM / DD)	First Name / Last Name (if different than Plan Member)	Relationship to Employee	Amount Claimed

(NOTE: If additional space is required please fill out an additional claim form.)

Total Claim: \$

4. PAYMENT REQUEST

- Please reimburse for the attached Expenses.
- Please issue payment for all Expenses held in my Health Care Spending Account, including the attached Expenses.
- I do not wish to be reimbursed at this time.

5. EMPLOYEE CONSENT AND DECLARATION

I certify that the information contained in this and other documents supporting this claim is complete and true. **By submitting this form, I understand that I am requesting payment be made for the above expenses, in accordance with my Health Care Spending Account plan.** I accept full responsibility to ensure that all expenses incurred and submitted for payment from my Health Care Spending Account plan are allowable medical expenses as defined under the *Income Tax Act*. If unsure please visit Canada Revenue Agency's (CRA) web site and/or call **1-800-959-8281** to obtain an official ruling.

I certify that the individuals for whom this claim is made are eligible under my Health Care Spending Account plan.

I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependents will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my Health Care Spending Account plan. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure.

Signature of Plan Member _____
(required)

Date _____

This consent is obtained in accordance with Alberta's Health Information Act, of Alberta's Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.

Complete this form, attach your original receipts, sign and send to:

Alberta Blue Cross, 10009 - 108 Street NW, Edmonton, AB T5J 3C5

If you have any questions, please contact Customer Services at 1-800-661-6995.

Important Health Care Spending Account (HCSA) claiming information

Original Receipts

- Attach original receipts for each expense claimed and keep copies for your records. If you have claimed these expenses under another plan, the original Explanation of Benefits from that plan and copies of receipts must be attached to this claim.

Sample of a Health Care Spending Account (HCSA) claim form.



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- It is your responsibility to determine if your medical expenses are allowable under the Canada Revenue Agency's rules and guidelines.

1. PLAN MEMBER INFORMATION			
Surname	First Name	Alberta Blue Cross ID Number	
Address			Group Number 35
City	Province	Postal Code	Telephone Number

2. PLAN CHOICE	
The intent of this claim form is to submit expenses <u>directly</u> to your HCSA plan. If you would like Alberta Blue Cross to determine if the expenses below could be paid through your health/dental plan first before being sent to your HCSA plan, please check the box below:	
<input type="checkbox"/> Please pay eligible amounts through my health/dental plan first.	

3. CLAIM SUBMISSION DETAILS: (Remember to attach supporting receipts and/or statements from other benefits carriers.)				
Expense Description	Date of Service (YY / MM / DD)	First Name / Last Name (if different than Plan Member)	Relationship to Employee	Amount Claimed
(NOTE: If additional space is required please fill out an additional claim form.)				Total Claim: \$

4. PAYMENT REQUEST	
<input type="checkbox"/> Please reimburse for the attached Expenses	
<input type="checkbox"/> Please issue payment for all Expenses held in my Health Care Spending Account, including the attached Expenses.	
<input type="checkbox"/> I do not wish to be reimbursed at this time.	

5. EMPLOYEE CONSENT AND DECLARATION	
I certify that the information contained in this and other documents supporting this claim is complete and true. By submitting this form, I understand that I am requesting payment to be made for the above expenses. In accordance with my Health Care Spending Account plan, I accept full responsibility to ensure that all expenses incurred are submitted for payment from my Health Care Spending Account plan and allowable medical expenses as defined under the Income Tax Act. If unsure please visit Canada Revenue Agency's (CRA) web site and/or call 1-800-959-8281 to obtain an official ruling. I certify that the individuals for whom this claim is made are eligible under my Health Care Spending Account plan.	I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependents will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my Health Care Spending Account plan. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above. I understand that my personal information will be kept confidential and secure.
Signature of Plan Member (required)	Date

Complete this form, attach your original receipts, sign and send to: Alberta Blue Cross, 10009 - 108 Street NW, Edmonton, AB T5J 3C5
If you have any questions, please contact Customer Services at 1-800-661-6095

1. Plan Member Information
Please complete this section in full to ensure that your claims are processed promptly and accurately. Refer to your Alberta Blue Cross identification card for your ID number and group number.

2. Plan Choice
The intent of this claim form is to submit expenses directly to your HCSA plan.

However, if you choose the selection box, Alberta Blue Cross will determine if the expenses could be paid through your health/dental plan first before being sent to your HCSA plan. This would ensure that your health/dental plan is fully optimized before using HCSA credits.

3. Claim Submission Details
First Name/Last Name
Please provide the first name of the individual for whom the expense was incurred. If the surname is different than the Plan Member's, please provide this along with the first name.

Expense Description
Please list each expense separately with its date of service and amount to be claimed through your HCSA.

4. Payment Request
Please select a payment request option.

5. Plan Member Consent and Declaration

Signature of Plan Member
Signing this claim form acknowledges your responsibility to ensure that all expenses incurred and submitted are allowable medical expenses as defined under the Income Tax Act. Signing also gives you your consent to use personal information to determine eligibility for this benefit, validate, assess, adjudicate and administer your HCSA. You also acknowledge that as part of the claiming process you have been authorized by your spouse and eligible dependents to disclose and receive information about their claims.

ALC 81345, City of Edmonton, 15/05/2023