NO STAPLES PLEASE, PAPER CLIPS ONLY

ARTA BENEFIT PLANS

GENERAL CLAIM SUBMISSION FORM
(For Drug, Vision and Extended Health Claims)

Refer to page 2 for emergency out of province/country claims

SECTION 1 - PLAN MEMBER INFORMATION

BENEFIT ID NUMBER	EMAIL ADDRESS
SURNAME FIRST NAME	PHONE NUMBER
ADDRESS	
CITY PROVINCE	POSTAL CODE

SECTION 2 - MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? YES ☐ NO ☐

If Yes, please provide Insurance company's name _____

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Accident(YY/MM/DD)_____

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury(YY/MM/DD) _____

If yes, WSIB / WCB Case # _____

SECTION 3 - CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY	PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF SERVICE YR	MO	DAY	TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ITEM
									TOTAL CLAIMED	

FOR PRESCRIPTION DRUG CLAIMS ONLY:

TO FACILITATE CLAIMS PROCESSING:

- **Please note: Cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required.**
- **Original receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN)**
- **If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.**

If claim is from OUT OF COUNTRY, please provide:

Name of Country Visited _____ **Currency Used** _____ **Name of Drug** _____

SECTION 4 - AUTHORIZATION

_____ _____

SIGNATURE OF PLAN MEMBER DATE

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 Alberta Retired Teachers' Association about myself and my dependents, will be used by Alberta Retired Teachers' Association 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 Alberta Retired Teachers' Association 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 lawenforcement agencies.

SECTION 5 - MAILING INSTRUCTIONS (See reverse for claim submission instructions)

PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned. Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	OTHER CLAIMS
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1606
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	N9A 6W1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.

MEMBER SUPPORT CENTRE 1-855-444-ARTA (2782)

The listing below may include benefits not covered by your plan.

ARTA CLAIM SUBMISSION INSTRUCTIONS

Please call our Member Support Centre at 1-855-444-ARTA (2782) if you require any assistance in completing this form.
Please ensure that you always provide your ARTA ID Number in full, including suffix (ie. 00, 01, etc.).

FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM:
Audio (Hearing Aids)	Itemized receipts showing • patient name • services & dates • audiologist name & address • breakdown of charges (i.e. Acquisition cost, fee, mold)
Prescription Drugs	All itemized prescription drug receipts from your pharmacist. Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy.
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing • patient name • individual date & nature of treatment • charge for each service Some professional services may require a medical referral/physician prescription.
Durable Medical Equipment (including prosthetics)	Itemized receipts showing • patient name • a detailed description of the equipment • name & address of supplier • date & charge for each service Some medical equipment may require a medical referral/physician prescription and/or prior authorization.
Custom Foot Orthotics	Itemized receipts showing • patient name • name and address of supplier • charge for service • casting technique • date orthotics were received A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified by your plan sponsor.
Hospital Accommodation	Itemized receipts showing • patient name • number of days in semi-private/private accommodation • rate charged per day • admission & discharge dates
Vision Care	Itemized receipts showing • patient name • copy of vision prescription • a breakdown of charges for lenses & frames • date eyewear received or paid in full
Extended Health - General	Itemized receipts showing • patient name • a detailed description of services or supplies • provider's name & address • date & charge for each service Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.
Emergency Out of Province/Country	If your claim is for emergency medical expenses incurred while travelling out-of-province or out-of-country, complete an Allianz Emergency Medical Expense Claim Form (available on myarta.net) and return it, along with original receipts, to Allianz Global Assistance. Note that Emergency Travel coverage is only included in the Total Health and Ultimate Health options for Extended Health Care coverage. If you chose Health Wise or Health Wise Plus, you are not covered for Emergency Travel. Call Member Support Centre at 1-855-444-ARTA (2782) for detailed claims submission instructions
Private Duty Nursing	Call Member Support Centre at 1-855-444-ARTA (2782) for detailed claims submission instructions. Pre-approval is required for all nursing claims - call Member Support Centre for details.

Claim Submission Considerations

If you claimed through another Health Benefits Plan first, attach the Explanation of Benefits (EOB) to this claim form with a copy of the original receipt, invoice or statement.

Accidental dental claims require a completed Dental Care Claim form clearly identifying all injured teeth, the date of the accident, and an explanation of how the accident happened. Please make sure to write “dental accident” across the top of the first claim form you submit.

Claims must be received by ARTA before the end of the calendar year following the year the expense is incurred. For example, claims incurred in 2021 must be received before December 31, 2022. Claims received outside this period will not be paid.

Upon receipt of your payment, please retain the EOB for income tax purposes.