QUIKCARD™
Innovative Health Benefits

Vision Claim Form

Head Office
200 Quikcard Centre
17010 103 Avenue
Edmonton AB T5S 1K7

p 780.426.7526
f 780.425.1625
1.800.232.1997
quikcard.com

Or e-mail the completed form with a copy of your receipt to: claims@quikcard.com

Please Make Payment to: ◯ Provider ◯ Cardholder

Cardholder Information

Group #: _____ **Card #:** _____

Name: _____ **Date of Birth (D/M/Y):** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Patient Information (if not the cardholder)

Name: _____ **Date of Birth (D/M/Y):** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Is this vision treatment covered by any other vision plan? ◯ No ◯ Yes **If yes, name of Insurer:** _____

Provider Information (Required only if the payment is to the Provider)

License #: _____

Name: _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

*Must be Registered to receive payment directly from Quikcard. Visit www.quikcard.com for more information.

Sign Here _____ _____
Signature of Provider or Office Designate — Date

Date of Service		Procedure	Fee
		100 Exam	
		110 Glasses	
		120 Contacts	
		150 Low Vision Services	
		160 Other	

Statement & Authorization

CLAIMANT'S STATEMENT: I declare that the above statements are true and complete to the best of my knowledge and belief. I am authorized to provide and receive the personal information of my spouse and dependants to submit this claim and for benefit administration purposes and to give the authorization set out below on my own and any of their behalf.

PRIVACY NOTICE: The information requested in respect of this claim is required by Quikcard for benefit administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information consult Quikcard's privacy policy at www.Quikcard/privacy-policy.php or contact Quikcard by phone or mail.

QUIKCARD™
Confirmation Number
_____

AUTHORIZATION: I authorize for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Quikcard, all personal health information or any other information or records in its possession that is requested while and for the purpose of administering this claim. A photocopy of this authorization shall be as valid as the original.

COSMETIC SERVICES: I declare that the health services claimed on this form are medically required and not of a cosmetic nature.

◯ **Yes** ◯ **No** (A box must be checked in order for your claim to be processed.)

Sign Here _____ _____
Signature of Cardholder — Date

Clear Form Print Form