AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

CLAIM FORM

FOR MEDICAL EXPENSES AND PROFESSIONAL CARE

1. IDENTIFICATION OF INSURED PERSON

Client number	Date of birth (YYYY-MM-DD)	Telephone no.
Last name	First name	
Is this a new address? ☐ Yes ☐ No		
No.	Street	Apartment no.
City	Province	Postal code

2. MANDATORY DECLARATION

Are the expenses being claimed covered by other insurance? ☐ Yes ☐ No	If yes:
Insurance company's name	Holder of the other insurance contract
Is your spouse also a construction worker insured by MÉDIC Construction? ☐ Yes ☐ No	If yes, provide his or her client number
Is treatment due to a motor vehicle accident covered by the SAAQ? ☐ Yes ☐ No	If yes: Person's name: _____
Is treatment due to a work-related injury covered by the CNESST? ☐ Yes ☐ No	Date of the event (YYYY/MM/DD): _____
Is treatment due to an event indemnified by IVAC? ☐ Yes ☐ No	File no.: _____

The claim must first be submitted to the organization involved.

3. CLAIM DETAILS

Last name and first name	Patient's status	Date of birth (YYYY-MM-DD)	Type of expense	Date of service (YYYY-MM-DD)	Amount
	Main insured ☐ Spouse ☐ Child* ☐				
				TOTAL	

If it is an adult child, is the child a full-time student? ☐ Yes ☐ No

If child is a student, name of the educational institution* _____

* If your child is between 18 and 26 years of age, the child must be single and attending a recognized educational institution full time to be eligible for a claim. You are required to notify us of all changes to your list of dependents. You may do so at any time by accessing your online services.

4. AUTHORIZATION

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I attest that the information provided in this claim is complete and accurate. For the purpose of administration and evaluation of the claims and for fraud prevention, I authorize Médic Construction to obtain personal, medical, and psychosocial information and disclose it to the plan administrators and to regulatory and law enforcement agencies. I understand that the information will be used and preserved by Médic Construction for administration of benefits. Unless expressly revoked, the present authorization remains in force for the duration of claim processing. The information may be seen by the cardholder.

_____ _____

Mandatory signature by insured (employee or retiree) | Date (YYYY-MM-DD)

Claims must be submitted within one year from the date on which the expense was incurred.

Print

This document is available in adapted media upon request.

Please attach your ORIGINAL receipts and retain copies for your files as the original receipts will not be returned. Send your claim to the following address:

Médic Construction
Section de l'assurance maladie
C. P. 2212, succursale Chabanel
Montréal (Québec) H2N 0B8

For further information, please call Customer Services at 1 888 842-8282 or visit ccq.org.

MÉDIC CONSTRUCTION CLAIM SUBMISSION INSTRUCTIONS

Credit card statements, debit card slips, and cash register receipts are insufficient. Photocopies will be rejected.

Benefit type	Information required
Prescription drugs	Only original receipts itemizing the prescription drugs are accepted. As needed, contact your pharmacy to obtain a double copy of your receipts.
Professional services (paramedical services and alternative medicine)	Original receipt showing: - patient name - individual date and nature of treatment - charge for each service - the professional's name and address - the professional's membership number and the name of his or her association **A physician prescription is required to claim massage therapy, kinesitherapy, or orthotherapy services (valid for 12 months from the prescription date)**
Medical equipment (wheelchairs, crutches, prostheses, moulded shoes, etc.)	Original receipt showing: - patient name - detailed description of the equipment - supplier name and address - date and charge for each service **In all cases, a physician prescription with respect to the medical equipment is required, and, in certain cases, prior authorization of the Commission de la construction du Québec must be obtained.**
Foot orthotics	Itemized receipt showing: - patient name - supplier name and address - charge for the service - date orthotics received or paid in full **A physician prescription is required.**
Vision care	Original receipt showing: - patient name - breakdown of charges for lenses and frames - date of full payment for eyewear **For purchases of glasses or corneal contact lenses, a copy or details of the prescription regarding the invoice or receipt is required.**
Hearing aids	Itemized original receipt showing: - patient name - service dates and charges - audiologist name and address **A medical prescription is required.**
Hospitalization	Itemized original receipt showing: - patient name - number of days in accommodation - rate charged per day - admission and discharge dates
Ambulance transportation	The original itemized receipt and the user's transport declaration
Private duty nursing	Pre-approval is required for all nursing claims. Call Customer Services, at 1 888 842-8282, for details.