OTIP RAEO®

OTIP Health Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

1.866.783.6847
www.otipservices.com

# ARM Vacation Supply Routing Slip

**IMPORTANT:** Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

## PLAN MEMBER INFORMATION (Please Print)

| Plan Number | Identification Number | Plan Name |
|---|---|---|
| | | |

| Plan Member Name (First, Middle Initial and Last) | Date of Birth (mm/dd/yyyy) |
|---|---|
| | |

| Address (Number, Street and Apt.) | City/Town | Province | Postal Code |
|---|---|---|---|
| | | | |

## CLAIMANT INFORMATION (Complete for all expenses. Use one line per patient)

| CLAIMANT'S NAME | DATE OF SERVICE (mm/dd/yyyy) | DRUG IDENTIFICATION NUMBER | QUANTITY | NUMBER OF MONTHS (SUPPLY) | PLEASE SPECIFY WHICH MONTHS | DISPENSING FEE | TOTAL COST | PAYEE |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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## AUTHORIZATION

**NOTE - ORIGINAL RECEIPTS MUST BE ATTACHED FOR ALL EXPENSES.**

**Total amount of ALL receipts submitted** $ _____

**I certify** that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** OTIP and/or its Insurer to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, insurer, investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, its insurer, their reinsurers and/or service providers for the Purposes. **I agree** that a photocopy or electronic version of this authorization is valid. **I understand** that OTIP's privacy policy is available at www.otipservices.com or by request.

_____ _____

Signature of Plan Member Date (mm/dd/yyyy)

Any information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your information will be limited to:

- OTIP employees, representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

## MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

OTIP Health Claims
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Waterloo ON N2J 3Z9

## QUESTIONS

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