



OTIP Health Claims
 125 Northfield Drive West
 PO Box 218
 Waterloo ON N2J 3Z9
 1.866.783.6847
 www.otipservices.com

RTIP 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

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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