NO STAPLES PLEASE, PAPER CLIPS ONLY

OTIP RAEO

GENERAL CLAIM SUBMISSION FORM
each person must complete own claim form

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?
Go to www.otip.com for more details

SECTION 1 - PLAN MEMBER INFORMATION

OTIP ID -	EMAIL ADDRESS
SURNAME FIRST NAME	PHONE NUMBER
ADDRESS	COMPANY NAME
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 we are your secondary carrier, please attach copies of your receipt and your Explanation of Benefit statement from your primary carrier.

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, include date of accident _____

Include which expenses are MVA related _____

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, include date of injury _____ WCB Case # _____

Which expenses are a result of the work related incident _____

PATIENT'S NAME	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY

SECTION 3 - AUTHORIZATION AND CONSENT

I certify that I, and/or my eligible dependants ("Dependants"), have received all good or services claimed and that the information provided for this claim is true and complete.

I authorize OTIP and its service providers to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes").

I am authorized by my Dependants to disclose and receive their Information for the Purpose. I authorize any person or organization with Information, including any medical and health professionals, facilities or provider, professional regulatory bodies, any employer, plan benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP and its service providers for the Purposes.

I authorize the use of my OTIP ID number for the purposes of identification and administration, I agree a photocopy or electronic version of this authorization is valid.

I acknowledge that more specific details regarding how and why OTIP collects, uses, maintains, and discloses my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or by request.

I understand that any Information provided to or collected for the Purposes in accordance with this authorization, will be kept in a benefits health file.

Access to the Information will be limited to:
- OTIP and its service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

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

Name _____ Signature _____ Date _____

SECTION 4 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
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	DENTAL
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1608
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	N9A 7G1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above.

CLAIM SUBMISSION INSTRUCTIONS

Please call our RTIP Contact Centre at 1-833-318-2811 or (519) 739-0227 if you require any assistance in completing this form.
Please ensure that you always provide your OTIP 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: The listing below may include benefits not covered by your plan
Audio (Hearing Aids)	Itemized receipts showing patient name, services & dates, audiologist name & address, prescriber / dispenser information and audiogram.
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing patient name, individual date & nature of treatment, and the 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, and 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 & address of supplier, charge for service, casting technique, and 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, and admission & discharge dates
Vision Care	Itemized receipts showing patient name, copy of vision prescription, a breakdown of charges for lenses & frames, and 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, and date & charge for each service. **Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.**
Out of Province / Country	Call RTIP Contact Centre at 1-800-936-6226 or 519-742-3556 for detailed claims submission instructions.
Private Duty Nursing	Call RTIP Contact Centre at 1-833-318-2811 or 519-739-0227 for detailed claims submission instructions. Pre-approval is required for all nursing claims - call for details.
Prescription Drugs	Itemized prescription drug receipts from your pharmacist. **Receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN).** 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. If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees. If claim is from **OUT OF COUNTRY**, please also provide: **Name of Country Visited** _____ **Currency Used** _____ **Name of Drug** _____