Canadian HealthCare Administrators Inc.

For Corporations and Professionals

Employee Claim Form

Private Health Services Plan
For Corporations and Professionals

*Please ll in all areas, sign the form and mail with original receipts to address below.

Employer: _____

Employee Name: _____

Employee Number: _____

Claim Number: _____

Item #	Date of Service	Patient Name	Total $	Allowed Charges	Procedure Code	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

13	Total Medical Expenditures (Add Boxes 1-12):	
14	Administration Fee (10% of Box 13):	
15	GST #885428714RT0001 (5% of Box 14):	
16	Total Due (Add Boxes 13-15):	

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Phone: (587) 437-9028
Email: info@healthcareadmin.ca
www.healthcareadmin.ca

* I authorize the release of any information or records of this claim to the Plan Administrator and certify that the information given is true and correct to the best of my ability.

Employee Signature: _____

Date: _____ , 20 _____