BROCK
HEALTH ADMINISTRATION LTD.

BBB ACCREDITED BUSINESS

## CLAIM FORM (Pay-As-You-Go Plans)

Date: _____

Business or Company Name: _____

Name of Covered Employee: _____

Employee Email Address: _____

| Patient Name | Service Date | Description | Amount |
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| Use a separate sheet or spreadsheet printout if necessary.<br>If using multiple pages, please carry forward Total Claim Amount to last page. | | Total Claim: **A** | |
| | | Administration Fee (**A** x 5%): **B** | |
| TAX (on Administration Fee Only)<br>GST/HST No.<br>83077 8924RT0001 | GST<br>HST<br>HST | BC, AB, SK, MB, YT, NT, NU (**B** x 5%):<br>ON (**B** x 13%):<br>NS, NB, NL, PE (**B** x 15%): **C** | |
| | | Total Fee Payable: (**A** + **B** + **C**) | |

Employee certifies that all health services were purchased by or for an eligible member of their household.

Signature: _____

**14505 Bannister Road**
**Suite 103**
**Calgary, Alberta T2X 3J3**

**www.BrockHealth.ca**

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**FAX 1-866-492-9486**
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