COGNIGRAM™ - Healthcare Claim Form *(please print clearly)*

COGNIGRAM™ is a medical test prescribed by physicians to assist in the diagnosis and management of patients with cognitive impairment.

Member Information

Contract Number

Plan Sponsor (Employer)

Member ID

Address

Member First Name

City

Member Last Name

Province

Postal Code

Birthdate (MM/DD/YYYY)

Home Phone Number

Other Phone Number

Patient Information *(if patient is a spouse or child)*

First Name

Phone Number

Last Name

Relationship to Member

Birthdate (MM/DD/YYYY)

Physician's Information *(prescribed by)*

First Name

Address

Last Name

City

Phone Number

Province

Postal Code

Authorization and Claim *(attach receipt(s) and copy of physician's order(s) or requisition(s) if available and mail to your insurance company)*

Authorization and Signature

I certify that I, my spouse and/or my dependents have received all of the goods and/or services claimed. I certify that, to the best of my knowledge, the information contained on this form is accurate and complete. I understand that the information contained on this form includes personal information.
I hereby authorize my insurer, as well as its agents, representatives and service providers, to collect, use and disclose the information contained on this form (including personal information) only for the purposes of processing and managing this claim. I understand that the information contained on this form will otherwise be kept confidential. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Amount of receipts submitted $

Member Signature

Date signed (MM/DD/YYYY)

COGNIGRAM™ may not be covered by your health insurance plan. COGNIGRAM™ is not a diagnostic tool.

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