ALBERTA BLUE CROSS®

10009 108 Street NW, Edmonton, Alberta T5J 3C5

NATIONAL EMERGENCY OUT OF PROVINCE/ OUT OF COUNTRY CLAIM FORM

***All sections must be completed, before your claim can be processed.**

Member information* (*refer to your ID card*)

Member's last name	First name	Date of birth	
Mailing address		Home telephone number	
City	Province/state	Postal code/zip code	Work telephone number
Provincial health number	Travel plan ID number and /or	Policy number / Section	ID number
Name of Canadian physician	Address		Telephone number

Patient information (*please complete a separate form for each person*)

Patient's last name	First name	Date of birth	
Provincial health number		Relationship of patient to the primary plan member	
Reason for travel: ☐Vacation ☐School ☐Business ☐Treatment	Date of departure	Date of intended return	Date of actual return
Name of Canadian physician	Address		Telephone number

Claim information

Diagnosis (reason for seeking treatment)	Country claim incurred in	Currency claim incurred in	Have you already paid the provider for this service? ☐Yes ☐No

Type of product or service	Who provided the product or service?	Date of service	Amount claimed
☐ Ambulance			
☐ Prescription drugs			
☐ Physician services			
☐ Hospital			
☐ Transportation			
☐ Other: Meals and accommodation, vehicle return, funeral/return of deceased (please provide details)			

If this claim is due to an accident please complete this section (*police reports required for ALL motor vehicle accidents).*

Date of accident		Type and location of accident

Has a claim been made to recover damages from the responsible person(s)? ☐Yes ☐No | If no, do you intend to make a claim? ☐Yes ☐No

If you have coverage through another benefits carrier or Alberta Blue Cross Plan

(including credit card coverage, motor vehicle insurance, trip cancellation and/or trip interruption), please complete this section

Name of benefits carrier or if other Alberta Blue Cross Plan, the name of the employer	Has a claim been submitted to this carrier? ☐Yes ☐No
Address and phone number of benefits carrier	
Policy ID number or Alberta Blue Cross group, section and ID number	Name and date of birth of the primary plan member

Please ensure you read the information and sign on the next page ➔

Acknowledgement and consent

I certify that the information contained in this and other documents supporting this claim is true and complete. By submitting this form, I understand I am requesting payment for the listed expenses, in accordance with my benefit plan guidelines. I understand that the expenses listed may not be covered by, or may exceed, my plan benefits.

I understand that the personal information provided on this claim form, as well as any other personal information held by Alberta Blue Cross may be used or disclosed to administer my travel coverage and verify, assess and pay claims and audit or verify paid claims. I hereby acknowledge and agree that Alberta Blue Cross may collect personal information about me and my plan dependents from licensed physicians and/or any other healthcare professionals or institutions, health benefits or insurance companies, government programs and other third parties for the purposes outlined above and may disclose my personal information to these parties for the same purposes.

Specifically, by completing the *Insurance Claim Consent and Authorization* form, I authorize Alberta Health and Alberta Blue Cross to exchange all pertinent health information about me for the purposes stated above.

I understand that my personal information will be kept confidential and secure.

I understand that I may revoke my consent at any time and acknowledge that should I do so, my claim may not be considered. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

For prompt payment of your claim:

For prompt payment of your claim:

- ✓ **Submit original receipts and documentation.** Cash register receipts will not be accepted unless accompanied by an itemized account, pharmacy receipt or physician order. Paid receipts must include the name of the person claiming the expense.
- ✓ **Please read and complete all sections of this form. Please complete an original, separate form for each person.**
- ✓ **For reimbursement of services already paid:** please provide proof of payment (paid receipt or copy of cancelled cheque – both sides). In accordance with your policy, claims for expenses must be received by Alberta Blue Cross within 12 months from the date of service in order to be eligible.
- ✓ **Claimants who are Alberta residents:** some of the services you are claiming, such as physician and hospital services, may be partially covered under Alberta Health.
- ✓ **Claimants who have valid Alberta provincial health coverage:** to avoid delay in payment, complete and sign the attached ***Insurance Claim Consent and Authorization*** form so eligible payments can be coordinated with Alberta health.
- ✓ In order for Alberta Blue Cross to process your claim and collect the amount payable from Alberta Health you are required to **complete and include the attached Insurance Claim Consent and Authorization** (form AHC2102 (2016/04).
- ✓ **Claimants who are not Alberta residents:** you are required to submit all hospital and physician claims first to your provincial health plan for assessment, then to Alberta Blue Cross, along with the assessment statement from your provincial health plan.

Authorization of payment

I authorize any health benefits or insurance companies to release payments to Alberta Blue Cross and for Alberta Blue Cross to release pertinent payments to other parties for the purposes of processing my travel coverage claims.

By signing this form, I acknowledge I have read and understood the Acknowledgement and Consent and Authorization of Payment, and agree to the collection, use and disclosure of my personal information as described above.

Signature of patient *(or parent/guardian if patient is a minor)*	**Signature of primary plan member**	*Date (YYYY-MM-DD)
Printed name of patient *(or parent/guardian if patient is a minor)*	Printed name of primary plan member	***This consent will be valid for one year from the date you sign it.*

Note: This consent complies with Alberta's Health Information Act and Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act. For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to www.ab.bluecross.ca or email privacy compliance officer at privacy@ab.bluecross.ca.

Explanation of benefits and claims payment

An Explanation of Benefits statement, indicating how this claim was assessed, will be sent to the member to be used for income tax purposes or to claim under other coverage. If you are being reimbursed, a cheque will accompany the statement. If your claim is complete with all the necessary receipts and documents, the Explanation of Benefits and cheque (if appropriate) will be mailed approximately two weeks after we receive your claim.

Mail this claim with your **original receipts** to:

Alberta Blue Cross
Health Services Department
10009-108 Street NW
Edmonton AB T5J 3C5 Canada

FOR ALL INQUIRIES PLEASE CALL

1-888-873-9200

®*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. ®† Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. ABC 55053/30741 2019/12

Alberta Government

Insurance Claim Consent and Authorization

Alberta Health
Out-of-Country Claims Unit
10025 Jasper Avenue NW
PO Box 1360 Station Main
Edmonton AB T5J 2N3

Key Information for Requesting Reimbursement for an Insurance Claim

- Personal information and health information that Alberta Health collects and discloses is used for the purposes of payment of benefits to Secondary Insurers, Brokers or Third Party.
- The enclosed Insurance Claim Consent and Authorization form will provide the authority for Alberta Health to assign payments to the secondary insurers, brokers or third party. This means the payment for hospital and physician services the patient receives will be made directly to the secondary insurers, brokers, or third party.
- ***Authorization for the release*** of health information and personal information is **only** valid for services provided during the period between the From and To dates on page two.
- The ***effective date*** section of this consent is time sensitive to allow for medical service claim(s) processing, and is revocable at any time by the Alberta resident with written notice to the Out-of-Country Claims Unit of Alberta Health.

Form Completion Instructions

All sections of the form on the next page must be completed in full and proof of payment provided. Omissions will result in an insurance claim not being processed.

Patient Information

- **Name of Patient** - print the full legal name of the patient who is receiving health services outside of Canada.
- **Alberta Personal Health Number** (PHN) - this is a unique 9-digit number assigned to all Albertans registered with the Alberta Health Care Insurance Plan that appears on the Alberta Health Care card.

Authorization for Release of Health Information

- **Information can be released to** - Write the name of insurance company, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer that is authorized to receive the patient's personal or health information.

Authorization of Payment

- This allows insurance company, broker or third party who is not an insurer to receive payment from Alberta Health for the health services received by the patient outside of Canada.
- **Name of payee** - write the name of the Payee which is the insurance company, broker submitting on behalf of the insurance company, or third party who is paying for the claims. This authorizes Alberta Health to pay the insurance company, broker or third party directly.

Effective Date

- The consent is only for the date range provided. **Note**: The patient can change the consent dates at any time by providing written notice to Alberta Health.
- **Departure Date** - The date the patient will leave Alberta to receive the approved health services.
- **To Date** - provide a date that is 18 months past the expected end of treatment date. The healthcare provider has up to 365 days from the date of medical service to submit a claim.

Signature

- By signing, you are declaring that the information provided on the form is true and correct to the best of your knowledge; that you authorize the sharing of the provided personal or health information for the purposes of Alberta Health reimbursing an insurance company, broker or third party for the cost of health services received by the patient while outside of Canada.
- The form **must** be signed by the Alberta resident or a duly legally authorized representative. If the form is signed by a legal representative that person must provide documentation at the time the form is submitted that identifies the specific legal relationship with the Alberta resident that allows that person to sign this form on behalf of the Alberta resident. Any documents submitted to show the legal representative's authority must be notarized copies. Notwithstanding any documentation submitted by a legal representative Alberta Health may request further confirmation as to the legal representative's authority to sign this form on behalf of the Alberta resident.

Submission

- Return a completed consent to your secondary insurance provider.
- This form must accompany the insurance claim.

Alberta Government

Insurance Claim Consent and Authorization

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

Note: Failure to complete all sections of this form will result in Alberta Health not releasing health information or reimbursing an insurance claim. Proof of payment must be submitted with the insurance claim.

Patient Information

_______________________ Alberta Personal Health Number (PHN) _______________

Name of Patient - please print | PHN of Patient

Authorization for Release of Health Information

My health information can be released to:

CanAssistance Inc. on behalf of Alberta Blue Cross

Name of insurance company, and where applicable, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer (e.g. junior hockey clubs, churches).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, _______________________ hereby assign to CanAssistance Inc.

Name of Patient | Name of Payee

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From _______________ (Departure date)

Date *(yyyy-mm-dd)*

To _______________ (at least 18 months from the earliest date of service to ensure sufficient time for processing). Please note: the submitter has up to 365 days from the date of medical service to submit a claim to Alberta Health.

Date *(yyyy-mm-dd)*

Declaration

I, the patient, authorize disclosure of the following information for the purposes of Alberta Health to reimbursing health benefits paid on my behalf for the cost of insured health services received outside of Alberta, which may include the following: date(s) of service(s), type(s) of service(s) and reason(s) for service(s), amount(s) paid, name(s) of service provider(s), and where applicable, the facility name, and personal health number.

I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified insurance company, or third party who is not an insurer that has paid a medical service claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

I, certify that the information provided above on this form is true and correct.

_______________________ | _______________________

Please print name of person signing

Signature of person completing request (if 18 years of age and over)

- or -

Signature of authorized representative (if person completing request is under 18 years of age or wholly dependent on the authorized representative by reason of mental or physical infirmity).

Please return this completed form to secondary insurance company.

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must be a legal representative of the resident and must be accompanied by notarized copies of any legal documents that establish to the satisfaction of Alberta Health the individual's legal authorization to sign on behalf of the resident.

Alberta Government

Insurance Claim Consent and Authorization

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

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Patient Information

Alberta Personal Health Number (PHN) ______________

Name of Patient - please print ______________ PHN of Patient ______________

Authorization for Release of Health Information

My health information can be released to:

Alberta Blue Cross

Name of insurance company, and where applicable, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer (e.g. junior hockey clubs, churches).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, ______________ (Name of Patient) hereby assign to Alberta Blue Cross (Name of Payee)

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From ______________ Date *(yyyy-mm-dd)* (Departure date)

To ______________ Date *(yyyy-mm-dd)* (at least 18 months from the earliest date of service to ensure sufficient time for processing). Please note: the submitter has up to 365 days from the date of medical service to submit a claim to Alberta Health.

Declaration

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I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified insurance company, or third party who is not an insurer that has paid a medical service claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

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