ALBERTA BLUE CROSS®

IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you have not made any payments. Your provincial health plan covers partially some of the fees for medical care received during your trip. Alberta Blue Cross' travel assistance provider CanAssistance Inc. reimburses these fees in full and will collect the amount payable on your behalf.

Filing a claim

Complete and sign all forms
- Each person who received healthcare services must complete a claim form.
- Ensure you also complete and submit **both** « Insurance Claim Consent and Authorization » forms.

Attach the following documents:
- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly.
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Any other relevant document(s), such as medical reports, lab results, etc.

Mail this claim and all required documents to: **Alberta Blue Cross, Travel Claims Department**
PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7

Additional Information

You may make copies of all submitted documents for your files, as they will not be returned.

Your claim will be reviewed as quickly as possible once we have received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the Primary plan member. If you are covered by more than one travel insurance policy, indicate this on your claim form. We will work with the other issuer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact our customer service toll-free at 1-888-772-2583 or at 1-403-225-4289 Monday through Friday from 8:30 am to 8:00 pm (EST) or by email at bluecross@canassistance.com.

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ALBERTA BLUE CROSS®

TRAVEL INSURANCE CLAIM FORM

TRAVEL ID NUMBER

PATIENT INFORMATION (please complete separate form for each person)

PROVINCIAL HEALTH NUMBER

LAST NAME

LAST NAME AT BIRTH (if different)

FIRST NAME

DATE OF BIRTH YEAR MONTH DAY

SEX ☐ M ☐ F

PERMANENT ADDRESS IN CANADA

POSTAL CODE

TELEPHONE NO. HOME AREA CODE WORK AREA CODE

STAY OUTSIDE CANADA/PROVINCE

DATE OF DEPARTURE DAY MONTH YEAR

DATE OF RETURN: (REAL OR PLANNED) DAY MONTH YEAR

REASON FOR TRIP

☐ VACATION

☐ WORK NAME OF EMPLOYER:

☐ STUDIES INCLUDE A WRITTEN CERTIFICATE FROM THE INSTITUTION:

☐ OTHER DESCRIBE:

SERVICES AND CARE RECEIVED

INDICATE THE REASON WHY YOU RECEIVED MEDICAL OR HOSPITAL SERVICES:

DESCRIBE THE CARE RECEIVED (E.G.: EXAMINATION, X-RAYS, SURGERY, ETC.) IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.

CITY AND COUNTRY WHERE THE SERVICES WERE RECEIVED:

IN THE CASE OF AN ACCIDENT, INDICATE:

DATE OF THE ACCIDENT DAY MONTH YEAR

TYPE OF ACCIDENT: ☐ TRAFFIC ☐ WORK RELATED ☐ OTHER (SPECIFY):

HAVE THE BILLS BEEN PAID? ☐ YES ☐ NO **IF YES:** ☐ IN FULL ☐ PARTLY

AMOUNT PAID

CURRENCY ☐ CANADIAN DOLLARS ☐ OTHER (SPECIFY):

DO YOU HAVE OTHER INSURANCE COVERING THESE COSTS? ☐ YES ☐ NO

IF YES: INSURER'S NAME: POLICY NO. :

IF THAT COVERAGE IS FROM YOUR CREDIT CARD, PLEASE INDICATE YOUR CREDIT CARD NUMBER:

MEDICAL INFORMATION BEFORE DEPARTURE

DOCTOR AND SPECIALIST (IF APPLICABLE) IN CANADA BEFORE DEPARTURE :

NAME ADDRESS

NATURE OF ILLNESS : DATE OF LAST VISIT : DAY MONTH YEAR

HAVE YOU BEEN HOSPITALIZED IN CANADA IN THE LAST 6 MONTHS PRIOR TO YOUR TRIP ? ☐ YES ☐ NO

NATURE OF ILLNESS

NAME OF HOSPITAL CITY

ADMISSION DATE DAY MONTH YEAR FILE NUMBER:

LIST THE MEDICATION(S) YOU WERE TAKING DURING THE 6-MONTH PERIOD PRECEDING YOUR DEPARTURE :

CONSENT AND AUTHORIZATION

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 OR ITS TRAVEL ASSISTANCE PROVIDER CANASSISTANCE AND AFFILIATES 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 OR ITS TRAVEL ASSISTANCE PROVIDER CANASSISTANCE AND AFFILIATES 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, ALBERTA BLUE CROSS AND ALBERTA BLUE CROSS' TRAVEL ASSISTANCE PROVIDER CANASSISTANCE AND ITS AFFILIATES 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.

I AUTHORIZE ANY HEALTH BENEFITS OR INSURANCE COMPANIES TO RELEASE PAYMENTS TO ALBERTA BLUE CROSS OR ALBERTA BLUE CROSS' TRAVEL ASSISTANCE PROVIDER CANASSISTANCE AND ITS AFFILIATES AND FOR ALBERTA BLUE CROSS OR ALBERTA BLUE CROSS' TRAVEL ASSISTANCE PROVIDER CANASSISTANCE AND ITS AFFILIATES 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 PATIENT'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY | PRINT NAME | DATE

PRIMARY PLAN MEMBER (IF DIFFERENT FROM THE PATIENT)

LAST NAME | FIRST NAME | AGE

PROVINCIAL HEALTH NUMBER:

TELEPHONE: HOME ( ) WORK ( )

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ATTENTION: READ CAREFULLY

PLEASE SIGN THE CLAIM FORM. KEEP A COPY OF ALL THE DOCUMENTS, INCLUDE THE ORIGINAL COPY OF ALL YOUR RECEIPTS AND SEND TO THE FOLLOWING ADDRESS:

NOTICE: FAILURE TO INDICATE YOUR PROVINCIAL HEALTH INSURANCE NUMBER SHALL RESULT IN THE COMPENSATION BEING REFUSED.

ALBERTA BLUE CROSS
TRAVEL CLAIMS DEPARTMENT
PO BOX 3888, STATION B
MONTREAL (QUEBEC) H3B 3L7

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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 <u>must</u> 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, ______________ hereby assign to Alberta Blue Cross

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)*

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Date *(yyyy-mm-dd)*

Declaration

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