# EMERGENCY MEDICAL EXPENSE CLAIM FORM

Claims Department
Box 93149, 1111 Davis Dr.
Newmarket ON L3Y 8K3

Toll Free Tel.: 1-866-772-5577
Toll Free Fax: 1-888-706-3430

**Please complete, sign and return promptly. Without this information, we are unable to proceed with your claim.**

## PATIENT INFORMATION

Patient Name | Policy # | Claim #

Address | City | Province Select | Postal Code

Patient's Date of Birth (mm-dd-yyyy) ◯ Male ◯ Female | Email address (if any)

Patient's Provincial Health Card Number *(including version code for Ontario residents)*

## TRAVEL DETAILS

Was this your first trip outside of your home province this year? ◯ Yes ◯ No, this was my ____ stay outside my home province this year.

Departure Date (mm-dd-yyyy) | Anticipated/Scheduled Date of Return (mm-dd-yyyy) | Actual Return Date (mm-dd-yyyy)

Nature of travel ◯ Business ◯ Vacation ◯ Study ◯ Medical Care ◯ Other | Destination

Mode of travel ◯ Car ◯ Airplane ◯ Other | If applicable, was Extension of coverage purchased? ◯ No ◯ Yes (specify)

## OTHER INSURANCE INFORMATION

**Employer Information**
**If retired, provide name of last employer providing benefits:**

Employer Name | Retired? ☐
Address
Telephone

Spouse's Name
Spouse's Date of Birth (mm-dd-yyyy)
Spouse's Employer | Retired? ☐
Address
Telephone

**Please indicate all other insurance coverage you have through any other insurer:** (i.e. employee/retiree/spousal group benefits, enhanced credit cards, personal property such as home, auto or any other purchased travel insurance plan). If necessary, please use an additional page.

1) Name of Insurance Company | Telephone
Address | Does this policy have a lifetime payable limit? ◯ No ◯ Yes (specify)
Policy # | Certificate # | Signature of Policyholder NOTE: If you have other insurance, you must sign this section by hand after printing out the form.

2) Name of Insurance Company | Telephone
Address | Does this policy have a lifetime payable limit? ◯ No ◯ Yes (specify)
Policy # | Certificate # | Signature of Policyholder NOTE: If you have other insurance, you must sign this section by hand after printing out the form.

3) **If Motor vehicle accident:** Name of Insurance Company: | Telephone
Policy # | Certificate #

4) **If trip purchased on Credit Card** please specify name | Number | Expiry Date Month Year

Have any of these bills been filed with any other company? ◯ No ◯ Yes | If Yes, name of company

Telephone | Contact person

*Page 2 of this form must be completed.* Page 2

**Additional documentation may be required for this claim - see below**

- ☑ All original, itemized medical bills and prescription receipts if received by patient
- ☐ Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)
- ☐ Proof of Departure
- ☑ Photocopy of the patient's Provincial Health Card
- ☐ Accident Report (if applicable)

(WHEN SUBMITTING ORIGINAL DOCUMENTS, PLEASE BE SURE TO KEEP A COPY FOR YOUR RECORDS.)

**If you have questions, please call us at 1-866-772-5577. Our Claims Service Team can help.**

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## MEDICAL INFORMATION

Were medical services required as the result of an accident? Yes No If "Yes", please provide details and include an accident report with this form.

Whether sickness or accident, please describe briefly the situation leading to you seeking medical attention, including the diagnosis.

Name of Hospital/Clinic

Date of Occurrence (mm-dd-yyyy)

Did you call our assistance line within 24 hours? Yes No

Do you have any other claims with us? Yes No

Have you had any of these conditions before? Yes No If "Yes", indicate the date you were **last** treated (mm-dd-yyyy)

Please list all medications in use **before** your departure date

Any medication change **before** your departure date? Yes No If "Yes", provide details on an additional page.

Name, address and phone # of your Family Physician in Canada

Date of your **last** medical visit in Canada before your trip (mm-dd-yyyy)

Country where claim occurred

Have you paid for your treatment? (If "Yes", please submit proof of payment) Yes No Full Partial

Total amount being claimed $

Currency

## PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND ASSIGNMENT

I direct and authorize my provincial Government Health Insurance Plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to Complete Claims Management Professionals Ltd. directly and I hereby release GHIP, upon payment to Complete Claims Management Professionals Ltd. from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out-of-country services [pursuant to Section 39 (1) of the Freedom of Information and Protection of Privacy Act, Section 4(2)(f) of the Health Insurance Act in Ontario only, and the Personal Health Information Protection Act].

I consent to the disclosure by GHIP, including OHIP, to Complete Claims Management Professionals Ltd. of such personal information including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information, however, if I do so my claim cannot be considered for payment. In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to Complete Claims Management Professionals Ltd..

Insured's Signature NOTE: You must sign this section by hand after printing out the form.

Date (mm-dd-yyyy)

GHIP #

Witness Signature NOTE: The witness to your signature must also sign this section by hand.

Date (mm-dd-yyyy)

Version Code (Ontario Residents only)

## CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given are complete, current and accurate to the best of my knowledge and belief.

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Complete Claims Management Professionals Ltd. or its representatives any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

I authorize any other insurance carrier to release and exchange with Complete Claims Management Professionals Ltd. or its representatives any medical or benefit payments information relating to this claim, and I authorize and direct such payors to forward payment directly to Complete Claims Management Professionals Ltd.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand I have a right to receive a copy of this authorization.

Name of Patient (Please print)

Date (mm-dd-yyyy)

Canadian Address

Signature of Patient / Designated Legal Proxy* NOTE: You must sign this section by hand after printing out the form.

Telephone #

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

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