MEDIPAC ASSIST

EMERGENCY MEDICAL EXPENSE CLAIM FORM

PLEASE PRINT CLEARLY. ALL SECTIONS MUST BE COMPLETED IN FULL. RETURN WITHIN 21 DAYS OF RECEIPT

PATIENT INFORMATION

Patient Name:		Policy Number:
Date of Birth (dd/mm/yyyy): _____ _____/ _____ _____/ _____ _____ _____ _____ ☐ Male ☐ Female		Deductible Amount:
Provincial Health Number *[Please attach a photocopy of card]*: (including version code for Ontario residents)		Province of Residence:
Departure Date:	Scheduled Return Date:	Actual Return Date:
Any extensions of coverage:	Conveyance of Travel: ☐ Car ☐ Plane ☐ Other :_____	Is this claim being made on an annual plan? ☐ Yes ☐ No

WHEN RETURNING THIS FORM, PLEASE ENCLOSE THE FOLLOWING DOCUMENTS:

☐ Deductible in U.S. Funds	☐ All original medical bills and prescription receipts	☐ A photocopy of the insured's provincial health card
☐ Proof of departure date	☐ Completed government health insurance claim forms *(Alberta, B.C. and Quebec residents only)*	

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

CO-ORDINATION OF BENEFITS INFORMATION

This section must be completed to ensure prompt handling of your claim

Name, address and telephone number of current employer *(if retired, provide name of last employer)*		If unemployed at time of loss, check here: ☐
Employer Name:	Employer Address:	Employer Telephone:
Spouse's Name:	Spouse's Employer:	Spouse's Employer Address:
Please indicate all other insurance you hold through any other insurer (i.e. employee/spousal group benefits, retiree group benefits, bank/credit card, benefits purchased with home or auto insurance policy).		
Name of Insurance Company:		
Address:	Telephone:	Does this policy have a lifetime Maximum? ☐ Yes ☐ No
Group No.:	Policy/Certificate No.:	If Yes, please state amount: $
Have you filed any bills with another company? ☐ Yes ☐ No	Name of Company:	Telephone:
Contact Person:		

MEDICAL INFORMATION

Give a brief, clear description of the situation leading to the need to seek medical attention. If the medical services were provided as a result of an accident, please provide us with details of this accident:		
Date of occurrence:	Country where claim occurred:	Do you have any other claims with us for this season? ☐ Yes ☐ No
Have you had any of these conditions before?	If "YES", indicate the date you were last treated (includes taking medications):	
Have you paid the account? *[If yes please submit proof of payment]* ☐ Yes ☐ No ☐ Full ☐ Partial		Total amount being claimed : $ Currency
Please list all medications in use before your departure date *[use a separate sheet if necessary]*:		
Date medications last changed (type or dosage) before your departure date:		Date of your last medical visit:
Name and telephone number of Family Physician:		

CERTIFICATION & AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the answers given are complete, current and accurate to the best of my knowledge and belief. I hereby authorize any physician, practitioner, health-care provider, hospital, health-care institution, medical organization, clinic and any other medical or medically related facility, insurance company, Worker's Compensation Board or similar plan or organization, and the Ministry of Health to release and exchange with Medipac International Inc, Medipac Assistance International Inc. (Medipac Assist) and Old Republic Insurance Company of Canada, or representatives thereof, my complete medical records, including medical treatment provided by my Primary Care Physician and treatment I received, am about to receive or may receive in the future. I authorize the period of 12 months, from the date of my notice of claim, as the period of access to and disclosure of my individually identifiable health information in accordance with the Canadian PIPEDA (Personal Information Protection and Electronic Documents Act) and U.S. HIPAA (Health Insurance Portability and Accountability Act) Privacy Practices. A photocopy of this authorization shall be as valid as the original.

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 the claim, but not to exceed one year from the date it is signed. I understand I have a right to receive a copy of this authorization.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the *Insurance Act* or other legislation that applies to your claim.

SPECIAL GOVERNMENT HEALTH INSURANCE PLAN DIRECTION

I irrevocably direct and authorize the Ministry of Health to make payment in respect of my claim for out-of-country health services to Medipac Assistance International Inc. directly and I hereby release the Government Health Insurance Plan, upon payment to Medipac Assistance International Inc. from any further claim or cause of action in connection therewith.

I authorize the Ministry to collect my personal health information, consisting of: information relating to my receipt of health care services outside of Canada, and information relevant to the reimbursement of those services under the Health Insurance Act [R.S.O. 1990, c. H.6, Ontario only] from Medipac Assistance International Inc., and authorize the Ministry to disclose such personal Health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, Including the details of any duplicate payment previously made to me, to Medipac Assistance International Inc.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form. However, my claim can not be processed without a fully completed claim form.

X _____
Name of Insured (Please Print)

X _____
Address

X _____
Canadian Telephone Number

X _____
Other Telephone Number

X _____
Signature

X _____
Date

X _____
Witness Name

X _____
Address

X _____
Canadian Telephone Number

X _____
Other Telephone Number

X _____
Witness Signature

X _____
Date