ALBERTA BLUE CROSS®

EMERGENCY OUT OF PROVINCE/ OUT OF COUNTRY CLAIM FORM

Mail this claim with your original receipts to: **Alberta Blue Cross, Health Services Department, 10009-108 Street NW, Edmonton AB T5J 3C5 Canada**

For prompt payment of your claim:

- ✔ **Submit original receipts and documentation.** *We will not accept photocopies or faxed invoices. 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, INCLUDING THOSE ON THE NEXT PAGE (PAGE 2). 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.
- ✔ **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 (2013/05)).**
- ✔ **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.*

1. Cardholder Information: (refer to your ID card)

CARDHOLDER'S LAST NAME	FIRST NAME			DATE OF BIRTH Year / Month / Day
MAILING ADDRESS				HOME TELEPHONE NUMBER
CITY	PROVINCE / STATE		POSTAL / ZIP CODE	WORK TELEPHONE NUMBER
PROVINCIAL HEALTH NUMBER	TRAVEL PLAN ID NUMBER	AND /OR	GROUP NUMBER / SECTION	ID NUMBER
NAME OF CANADIAN PHYSICIAN	ADDRESS			TELEPHONE NUMBER

2. Patient Information: (please complete a separate form for each person)

PATIENT'S LAST NAME	FIRST NAME		DATE OF BIRTH Year / Month / Day
PROVINCIAL HEALTH NUMBER	RELATIONSHIP OF PATIENT TO CARDHOLDER:		
REASON FOR TRAVEL ☐ Vacation ☐ Business ☐ School ☐ Treatment	**DATE OF DEPARTURE** Year / Month / Day	**DATE OF INTENDED RETURN** Year / Month / Day	**DATE OF ACTUAL RETURN** Year / Month / Day
NAME OF CANADIAN PHYSICIAN	ADDRESS		TELEPHONE NUMBER

3. 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 (Year/Month/Day)	AMOUNT CLAIMED
☐ Ambulance			
☐ Prescription Drugs			
☐ Physician Services			
☐ Hospital			
☐ Transportation			
☐ Other: Meals and Accommodation, Vehicle Return, Funeral / Return of Deceased (Please provide details)			

IN ADDITION TO COMPLETING THIS PAGE, PLEASE READ AND SIGN THE NEXT PAGE (PAGE 2).

CLAIMANTS WHO ARE ALBERTA RESIDENTS: 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.

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

DATE OF ACCIDENT	Year	Month	Day	TYPE & LOCATION OF ACCIDENT
Has a claim been made to recover damages from the responsible person(s)? ☐ No ☐ Yes				If no, do you intend to make a claim? ☐ No ☐ Yes

5. If you have coverage through another benefits carrier or 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 Blue Cross Plan, the name of your employer:	Has a claim been submitted to this carrier? ☐ No ☐ Yes
Address and phone number of benefits carrier:	
Policy ID number or Blue Cross Group, Section and ID number:	Name and Date of Birth of Cardholder:

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/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.

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 Cardholder

____
*DATE (Year / Month / Day)

____
Printed name of Patient (or Parent/Guardian if patient is a minor)

____
Printed name of Cardholder

**This consent will be valid for one year from the date you sign it.*

PRIVACY NOTE The collection, use and disclosure of information authorized on this claim form is pursuant to section 41 of the *Alberta Health Care Insurance Act*, sections 17, 33, 34, 39 and 40 of the *Freedom of Information and Protection of Privacy Act (Alberta)*, and sections 20, 21, 27 and 34 of the *Health Information Act*. For more information about Alberta Blue Cross privacy policies or the collection, use or disclosure of your/your dependents' personal information, visit www.ab.bluecross.ca, call our privacy matters representative at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 – 108 St NW, Edmonton, AB T5J 3C5.

CLAIMANTS WHO ARE ALBERTA RESIDENTS: 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.

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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 Submitting an Insurance Claim

Consent and Authorization:

- All sections of the form on the next page must be completed in full and proof of payment provided. Omissions will result in a claim not being processed.
- If a patient's medical information is being released by the insurance company to a broker, the name of the broker must also be identified on this form.
- The form must be signed by the Alberta resident. If someone other than the resident signs, notarized copies of legal documentation (e.g. legal guardianship, power of attorney, trusteeship, proof of custody, etc.) must be provided to identify the individual's relationship to the resident and their authority to sign.
- ***Authorization for release of information*** is only valid for services provided during the period the insurance coverage is in force (e.g. the period between the departure and return dates). However, the ***effective date*** of the consent is time sensitive (e.g. 3 - 12 months), to allow for claim(s) processing, and is revocable at any time by the Alberta resident with written notice to Alberta Health.
- This form must accompany the claim. An incomplete form will result in the claim not being processed and it will be returned for the required information to be provided.
- All supporting documentation must be in English.
- Reimbursement will only be made payable to the insurance company providing the resident's coverage, or to the named third party who is not an insurer.

Making the Claim:

The following information must be legible and clearly identified on the claim and submitted with this form. Please note that claims must be submitted within 365 days from the date the claimed services were provided.

Insurance Company or Third Party (who is not an insurer) ***identification:***

- Insurance Company/Third Party (e.g. junior hockey clubs, churches) name and contact information.

Patient identification:

- Patient's full name and date of birth.
- Patient's Alberta Personal Health Number.

Medical details:

- Details of the injury or medical condition (diagnosis), which required medical attention must be provided (e.g. fractured foot, chest pains, upset stomach, etc.), and an indication of where the services were provided (e.g. a clinic, a doctor's office, hospital emergency room).
- Any medical details in a language other than English must be translated into English.

Billing information:

- Full name of health service provider, if a physician has provided services. If a facility or hospital, please include the full name and contact information of the hospital or facility where the services were obtained must be provided.
- The claim must clearly itemize the date(s) of service, type(s) of service(s) and costs associated with each service provided, as well as the patient's admission/discharge dates if services were provided at a facility.
- If the services were not paid in Canadian dollars, please state the currency used. Alberta Health will determine reimbursement in Canadian dollars.
- While original invoices are preferred, copies will be accepted as proof that the health service(s) have been paid on behalf of the Alberta resident.

AHC2102 Insurance Claim Consent and Authorization form is available on the Alberta Health website at www.health.alberta.ca/AHCIP/forms-claims.html.

Insurance Claim Consent and Authorization

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

Authorization for Release of Information

I or my representative hereby authorize disclosure of the following information for the purposes of Alberta Health to process claims for the reimbursement of health benefits paid on my behalf for the cost of insured health services received outside of Alberta:

- 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.

for ______________________________ , Alberta Personal Health Number (PHN) ____________ .

Name of Resident - please print | PHN of resident

This information can be released to:

Alberta Blue Cross

Name of insurance company, and where applicable, also 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).

I understand I have been asked to authorize disclosure of this information for Alberta Health to reimburse the insurance company, or third party who is not an insurer that has paid a claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure.

Effective Date

This consent is effective from ____________ to ____________

Date *(yyyy-mm-dd)* | Date *(yyyy-mm-dd)*

and may be revoked in writing by me at any time by advising the Out-of-Country Claims unit at the address on the previous page.

Authorization of Payment

I assign to Alberta Blue Cross

Name of insurance company, broker submitting on behalf of the insurance company, or third party who is not an insurer

whatever benefits may be payable to me or on my behalf for health services obtained outside of Alberta.

Signature

____

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 print name of person signing

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must provide notarized copies of legal documentation *(e.g. power of attorney, trusteeship, proof of custody)* clearly establishing the individual's relationship with the resident and authorizing that individual to consent on the resident's behalf.

For guidance in submitting a claim, see Key Information for Submitting an Insurance Claim on the first page of this document.