Out-Of-Province Hospital/Medical Insurance Claims Information Sheet

This document addresses frequently asked questions related to Out-of-Province Hospital/Medical Insurance claims

MEDICAL INJURY / SICKNESS CLAIMS

- The Out-of-Province Insurance Claim Form must be completed in full in order to process your claim. Please be sure to state **your departure** and **return** dates and **diagnosis**.
- In the event that the insured was initially seen in a hospital outside Canada, a copy of the *Hospital Discharge Report* must be submitted, if available.
- Claims for **Physiotherapy / Massage Therapy/ Brace expenses** must be accompanied by the original receipts and the written referral from the attending physician recommending physiotherapy treatment.
- Claims for **Brace expenses** must be for therapeutic or curative purposes only.
- Please submit the following documents with the claim form:
  1. **Proof of travel:** copies of airline tickets, accommodation receipts, etc. showing your departure and return dates from/to province of residence.
  2. A copy of your **provincial health insurance card**.
  3. **Original itemized bills and receipts**.
  4. A copy of your **credit card statement** outlining the exchange rate, if expenses were paid for on your credit card.

IMPORTANT

- The Out-of-Province Insurance Claim Form must be filed with the Company within 90 days of the date of the injury/illness. Attach only original receipts for all expenses being claimed.
- Please note that it is the responsibility of the claimant to report their claim to us and to provide to us the supporting documentation outlined above.
- If you have more than one insurance carrier, benefits are coordinated.
- In the United States, it is customary for the provider of a particular service to send individual invoices. All such invoices should be forwarded to our office for our review.

WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED...

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 1-3 weeks. Our response would be one of the following:

(A) Payment or Notification of Payment to a Provider

(B) Request for more information if required

(C) Acceptance or Denial of the claim with reasons

Return completed claim form to:

INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
Life and Health Claims Department, Special Markets Solutions
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Tel: 1-800-266-5667
www.solutionsinsurance.com

In providing claim forms for the convenience of the claimant, the Company does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.

iA Financial Group

Return to:
Life and Health Claims Dept.,
Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Out-Of-Province Hospital/Medical Insurance Claim Form

Please print in ink

Member's Surname | Member's Given Name | Policy Number

Patient's Name | Relationship to Member

Patient's Address :
Street

City | Province | Postal Code | Phone Number

Patient's Health Card Number and Verification Code | Patient's Date of Birth (D D / M M / Y Y Y Y)

If insured is a student, please provide name of School and/or name of School Board

Grade/Year | School Board No.

Out of Province

1. Departure Date (D D / M M / Y Y Y Y) | Return Date (D D / M M / Y Y Y Y) | Destination

2. Mode of Transportation | Reason for Trip

3. Family Physician
Name | Street | City | Prov. | Postal Code

4. First Physician Consulted
Name | Street | City | Prov. | Postal Code

5. Date of initial onset of illness or injury: (D D / M M / Y Y Y Y)

Date of Previous Occurrence or Treatment: (D D / M M / Y Y Y Y)

6. Diagnosis:

7. If hospitalized*, advise
Date of admission: (D D / M M / Y Y Y Y) | Discharge Date: (D D / M M / Y Y Y Y) | Name of Hospital

Address of Hospital:
Street

City | Province | Postal Code | Phone Number

***If available, please enclose a copy of the Hospital Discharge Report.**

Out of Province Continued

8. If illness, has the patient had this or similar illness before?

Yes ❑ No ❑

If yes, give dates

(D D/M M M/Y Y Y Y) (D D/M M M/Y Y Y Y)

9. Was the current treatment due to an emergency?

Yes ❑ No ❑

If yes, please explain

10. Was the patient advised to seek treatment for this condition in a place other than their normal province of residence?

Yes ❑ No ❑

If yes, please explain

11. Name of Employer

Name

Address: Street

City Province Postal Code Phone Number

12. Name of Company who carries your Group Hospital/Medical Insurance or Extended Health Plan

Policy /Group No. Identification/Certificate No.

13. Do you carry any other excess Hospital/Medical or Travel Insurance?

Yes ❑ No ❑

If Yes, Name of Company

14. Do you have a premium credit card (GOLD CARD) which provides out-of-province medical?

Yes ❑ No ❑

If Yes, provide details

15. If injuries are the result of an automobile accident, advise name of Insurance Company

Policy Number Claim Number Name of Insured, if other than yourself

Address of Insured, if other than yourself: Street

City Province Postal Code Phone Number

Authorization and Declaration

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information that the Company may need in their assessment of this claim.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Date Signed (D D/M M M/Y Y Y Y)

Signature of Insured Patient or Parent or Legal Guardian

Please attach original receipts for all eligible expenses being claimed. It is the entire responsibility of the claimant to obtain and forward the completed claim form as indicated and for any charge made for its completion.