ALBERTA BLUE CROSS®

10009 108 Street NW, Edmonton, Alberta T5J 3C5

NATIONAL EMERGENCY OUT OF PROVINCE/ OUT OF COUNTRY CLAIM FORM

***All sections must be completed, before your claim can be processed.**

Member information* (*refer to your ID card*)

Member's last name	First name			Date of birth	
Mailing address				Home telephone number	
City	Province/state		Postal code/zip code		Work telephone number
Provincial health number	Travel plan ID number	and /or	Policy number	Section	ID number
Name of Canadian physician	Address			Telephone number	

Patient information (*please complete a separate form for each person)*

Patient's last name	First name		Date of birth	
Provincial health number		Relationship of patient to the primary plan member		
Reason for travel ☐Vacation ☐School ☐Business ☐Treatment	Date of departure	Date of intended return	Date of actual return	
Name of Canadian physician	Address		Telephone number	

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	Amount claimed
☐ Ambulance			
☐ Prescription drugs			
☐ Physician services			
☐ Hospital			
☐ Transportation			
☐ Other: Meals and accommodation, vehicle return, funeral/return of deceased (please provide details)			

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

Date of accident		Type and location of accident	
Has a claim been made to recover damages from the responsible person(s)? ☐Yes ☐No		If no, do you intend to make a claim? ☐Yes ☐No	

If you have coverage through another benefits carrier or Alberta 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 Alberta Blue Cross Plan, the name of the employer	Has a claim been submitted to this carrier? ☐Yes ☐No
Address and phone number of benefits carrier	
Policy ID number or Alberta Blue Cross group, section and ID number	Name and date of birth of the primary plan member

Please ensure you read the information and sign on the next page ➔

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 or 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.

For prompt payment of your claim:

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- ✓ **Submit original receipts and documentation.** 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. 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.
- ✓ **Claimants who have valid Alberta provincial health coverage:** 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.
- ✓ 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 (2016/04).
- ✓ **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.

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 primary plan member**	*Date (YYYY-MM-DD)
Printed name of patient *(or parent/guardian if patient is a minor)*	Printed name of primary plan member	***This consent will be valid for one year from the date you sign it.*

Note: This consent complies with Alberta's Health Information Act and Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act. For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to www.ab.bluecross.ca or email privacy compliance officer at privacy@ab.bluecross.ca.

Explanation of benefits and claims payment

An Explanation of Benefits statement, indicating how this claim was assessed, will be sent to the member to be used for income tax purposes or to claim under other coverage. If you are being reimbursed, a cheque will accompany the statement. If your claim is complete with all the necessary receipts and documents, the Explanation of Benefits and cheque (if appropriate) will be mailed approximately two weeks after we receive your claim.

Mail this claim with your **original receipts** to:

Alberta Blue Cross
Health Services Department
10009-108 Street NW
Edmonton AB T5J 3C5 Canada

FOR ALL INQUIRIES PLEASE CALL

1-888-873-9200

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