CanAssistance

IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you have not made any payments. Your provincial health plan covers partially some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full and will collect the amount payable on your behalf.

Filing a claim

Complete and sign the claim form

- Each person who received healthcare services must complete a claim form.

Attach the following documents:

- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly.
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport, a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
- Any other relevant document(s), such as medical reports, lab results, etc.

Mail this claim and all required documents to:

Saskatchewan Blue Cross, Travel Claims Department
PO BOX 3888, Station B
Montreal, Quebec, H3B 3L7

Additional Information

You may make copies of all submitted documents for your files, as they will not be returned.

Your claim will be reviewed as quickly as possible once we have received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the Primary plan member. If you are covered by more than one travel insurance policy, indicate this on your claim form. We will work with the other issuer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact our customer service toll-free at 306 667-5299 or toll-free at 1 866 330-3633, Monday through Friday from 8:30 am to 8:00 pm (EST) or by email at bluecross@canassistance.com.

08CAN0037A (19-07)

CANADA

CanAssistance

TRAVEL INSURANCE CLAIM FORM

TRAVEL ID NUMBER

PATIENT INFORMATION (please complete separate form for each person)

PROV. HEALTH INS. CARD NO.	LAST NAME	LAST NAME AT BIRTH (if different)
	FIRST NAME	DATE OF BIRTH YEAR MONTH DAY / SEX ☐ M ☐ F

PERMANENT ADDRESS IN CANADA

	POSTAL CODE	TELEPHONE NO.	AREA CODE HOME	AREA CODE WORK

STAY OUTSIDE CANADA/PROVINCE

DATE OF DEPARTURE (DAY MONTH YEAR) — DATE OF RETURN: (REAL OR PLANNED) (DAY MONTH YEAR)

REASON FOR TRIP

- ☐ VACATION
- ☐ WORK — NAME OF EMPLOYER:
- ☐ STUDIES — INCLUDE A WRITTEN CERTIFICATE FROM THE INSTITUTION:
- ☐ OTHER — DESCRIBE:

SERVICES AND CARE RECEIVED

INDICATE THE REASON WHY YOU RECEIVED MEDICAL OR HOSPITAL SERVICES:

DESCRIBE THE CARE RECEIVED (E.G.: EXAMINATION, X-RAYS, SURGERY, ETC. IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.

CITY AND COUNTRY WHERE THE SERVICES WERE RECEIVED:

IN THE CASE OF AN ACCIDENT, INDICATE:

DATE OF THE ACCIDENT (DAY MONTH YEAR) — TYPE OF ACCIDENT: ☐ TRAFFIC ☐ WORK RELATED ☐ OTHER (SPECIFY):

HAVE THE BILLS BEEN PAID? ☐ YES ☐ NO **IF YES:** ☐ IN FULL ☐ PARTLY

AMOUNT PAID

CURRENCY ☐ CANADIAN DOLLARS ☐ OTHER (SPECIFY):

DO YOU HAVE OTHER INSURANCE COVERING THESE COSTS? ☐ YES ☐ NO

IF YES: INSURER'S NAME: POLICY NO. :

IF THAT COVERAGE IS FROM YOUR CREDIT CARD, PLEASE INDICATE YOUR CREDIT CARD NUMBER:

MEDICAL INFORMATION BEFORE DEPARTURE

DOCTOR AND SPECIALIST (IF NECESSARY) IN CANADA BEFORE DEPARTURE :

NAME — ADDRESS

NATURE OF ILLNESS : — DATE OF LAST VISIT : (DAY MONTH YEAR)

HAVE YOU BEEN HOSPITALIZED IN CANADA IN THE LAST 6 MONTHS PRIOR TO YOUR TRIP ? ☐ YES ☐ NO

NATURE OF ILLNESS

NAME OF HOSPITAL — CITY

ADMISSION DATE (DAY MONTH YEAR) — FILE NUMBER:

LIST THE MEDICATION(S) YOU WERE TAKING DURING THE 6-MONTH PERIOD PRECEDING YOUR DEPARTURE :

PATIENT'S AUTHORIZATION

1. I AUTHORIZE CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. AND ITS SIGNING OFFICERS AS MY ATTORNEYS TO RECEIVE IN MY NAME AND ENDORSE AND NEGOTIATE ON MY BEHALF, CHEQUES AND OTHER FORMS OF PAYMENT FROM MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN FOR THE REIMBURSEMENT OF CLAIMS RELATING TO HOSPITAL AND MEDICAL SERVICES INCURRED DURING A TRIP OUTSIDE MY PLACE OF RESIDENCE PURSUANT TO AND DURING THE PERIOD OF MY TRAVEL INSURANCE COVERAGE, INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE.
2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH AND I FURTHER INDEMNIFY MY PROVINCIAL HEALTH INSURANCE PLAN IN RESPECT OF SUCH PAYMENTS TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION.
3. I HEREBY CONSENT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO APPLICABLE PROVINCIAL LEGISLATION.
4. I CONSENT TO THE DISCLOSURE BY MY PROVINCIAL HEALTH INSURANCE PLAN TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR THE PROCESSING OF MY CLAIM FOR SUCH HEALTH SERVICES, INCLUDING THE DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.
5. I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, PROVIDER, INSURANCE COMPANY OR PRE-PAYMENT ORGANIZATION WHO HAS ATTENDED OR EXAMINED ME OR MY FAMILY MEMBERS TO FURNISH TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OR FOR THE PURPOSES OF COORDINATION OF BENEFITS ANY AND ALL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM, INCLUDING INFORMATION WITH RESPECT TO SICKNESS, INJURY, MEDICAL HISTORY, CONSULTATIONS, MEDICINES, OR TREATMENT AND COPIES OF ALL HOSPITAL RECORDS FOR ME OR MY FAMILY MEMBERS.

A PHOTOCOPY OF THIS AUTHORIZATION AS SIGNED BY ME, MY PARENT, GUARDIAN OR AUTHORIZED ATTORNEY SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF PATIENT OR PATIENT'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY — PRINT NAME — DATE

PRIMARY PLAN MEMBER (IF DIFFERENT FROM THE PATIENT)

LAST NAME	FIRST NAME	AGE
PROV. HEALTH INS. CARD NO.:	TELEPHONE: HOME ( )	WORK ( )

ATTENTION: READ CAREFULLY

PLEASE SIGN THE CLAIM FORM. KEEP A COPY OF ALL THE DOCUMENTS, INCLUDE THE ORIGINAL COPY OF ALL YOUR RECEIPTS AND SEND TO THE FOLLOWING ADDRESS:
NOTICE: FAILURE TO INDICATE YOUR PROVINCIAL HEALTH INSURANCE NUMBER SHALL RESULT IN THE COMPENSATION BEING REFUSED.

CANASSISTANCE
TRAVEL CLAIMS DEPARTMENT
PO BOX 3888, STATION B
MONTREAL (QUEBEC) H3A 3S3