Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

EMERGENCY OUT-OF-COUNTRY CLAIM

Please answer all questions to support timely processing of your claim

1. **Submit original receipts and documentation to the Alberta School Employee Benefit Plan (ASEBP).** *Photocopies or faxed invoices are not accepted. 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.*
2. **Complete all sections of this form.** Please complete a **separate form** for each person.
3. **Complete the Alberta Health Services Insurance Claim Consent and Authorization Form and return them with this claim form to ASEBP.**
4. **For reimbursement of services already paid:** *Please provide proof of payment (paid receipt or copy of cancelled cheque – both sides). In accordance with your plan, claims for expenses must be received by ASEBP **within 18 months** from the date of service in order to be eligible.*
5. **Claimants who are not Alberta residents:** *Submit all hospital and physician claims **first** to the claimant's provincial health plan for assessment, **then** to ASEBP.*

A. Covered member information *(Refer to your ASEBP ID card)*

Last name: _____ First name: _____ Date of Birth: YYYY / MM / DD

Mailing address: _____ Home phone number: ( ) _____

City: _____ Province: _____ Postal code: _____ Work phone number: ( ) _____

Provincial Health Number: _____ ASEBP Member ID No: Group 1 9 9 3 0 | Section | Member's ASEBP ID Number

B. Patient information *(Please provide a **separate form** for each person)*

Last name: _____ First name: _____ Date of Birth: YYYY / MM / DD

Provincial Health Number: _____ ASEBP ID #: _____ Relationship to covered member: _____

Reason for travel ☐ Vacation ☐ School ☐ Business ☐ Treatment

Date of departure: YYYY / MM / DD

Date of actual return: YYYY / MM / DD

Date of intended return: YYYY / MM / DD

C. Claim information

Diagnosis *(Reason for seeking treatment)* _____ Country claim occurred in? _____ Currency claim occurred in? _____ Have you already paid for this service? ☐ Yes ☐ No

Type of product or service	*Who provided the product or service?*	*Date of service (YYYY/MM/DD)*	*Amount claimed*
☐ Ambulance		/ /	
☐ Prescription Drugs		/ /	
☐ Physician Services		/ /	
☐ Hospital		/ /	
☐ Transportation		/ /	

☐ Other: Meals and Accommodation, Vehicle Return, Funeral/Returned of Deceased *(Please provide details)* _____

If this claim is due to an accident, please complete below:

Date of Accident YYYY / MM / DD

Type & 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

D. Other insurance coverage *(Please complete this section if you have coverage through another insurance plan)*

Other ASEBP Plan or Name of other Insurance plan: _____

Policy No.: _____ ID No.: _____ Name & date of birth of covered member: _____

E. Consent for the collection, use and disclosure of personal information

The personal information contained in this claim form and supporting documentation as well as other personal information held by ASEBP, or its Third Party Administrator, Alberta Blue Cross ("Third Party Administrator"), is used to determine eligibility of this benefit, verify, assess and pay claims and administer your group benefit plan. It may be necessary for ASEBP and its Third Party Administrator to disclose pertinent records, information or payments to other health benefit or insurance companies for this purpose.

I hereby authorize any licensed physician, other health care professionals or institutions, health benefits or insurance companies, government or regulatory authorities or third parties to release pertinent records, information or payments to ASEBP or its Third Party Administrator for the purposes described above.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I understand why the above information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect me and my dependants' eligibility to receive group benefits.

I certify that the information contained in this claim and supporting documentation is true, accurate and complete.

_____	_____	_____ / _____ / _____
Patient's or Guardian's (if minor) Signature	Covered Member's Signature	Date (YYYY/MM/DD)

If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy statement at www.asebp.ca/privacy.html, or contact the Privacy Officer at 780-431-4786. This consent is being obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act* of Alberta and, in relation to personal health information, section 34 of the *Health Information Act* of Alberta.

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 Requesting Reimbursement for 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 an insurance 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 the release*** of information is only valid for services provided during the period between the from and to dates on page two.
- The ***effective date*** section of this consent is time sensitive (e.g. 18 months), to allow for medical service claim(s) processing, and is revocable at any time by the Alberta resident with written notice to Alberta Health.
- This form must accompany the insurance claim. An incomplete form will result in the insurance 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 medical service claims must be submitted within 365 days from the date the claimed medical service(s) were provided, which may affect the from and to dates on page two of this form.

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

- Insurance Company/Third Party 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 has provided services, please include the full name and contact information of the hospital or facility where the services were obtained.
- 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 hospital.
- 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.

Alberta Government

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 an insurance claim. Proof of payment must be submitted with the insurance claim.

Authorization for Release of Information

I or my representative hereby authorize disclosure of the following information for the purposes of Alberta Health to reimburse 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 Patient - please print — PHN of Patient

This information can be released to:

Alberta Blue Cross on behalf of the Alberta School Employee Benefit Plan

Name of insurance company, and where applicable, 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 medical service 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 _____ (departure date)
Date *(yyyy-mm-dd)*

To _____ (at least 18 months from the earliest date of service to ensure sufficient time for processing). Please note: the submitter has up to 365 days from the date of medical service to submit a claim to Alberta Health.
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 on behalf of the Alberta School Employee Benefit Plan

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

_____
Please print name of person signing

_____
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).

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 requesting reimbursement for an insurance claim, see 'Key Information for Requesting Reimbursement for an Insurance Claim' on page one of this document.