

Allendale Centre East Suite 301, 6104-104 Street NW Edmonton | Alberta | T6H 2K7 Phone: 1-877-431-4786 Fax: 1-780-438-5304 www.asebp.ca

EMERGENCY TRAVEL CLAIM

Instructions:

- 1. For claimants who are not Alberta residents, you'll need to submit all hospital and physician claims first to the claimant's provincial health plan for assessment, then to the Alberta School Employee Benefit Plan (ASEBP).
- Complete all sections of this form, including the Alberta Health Services Insurance Claim Consent and Authorization form (all three pages), and return to ASEBP to support timely processing of your claim. Please complete a separate form for each person.
- 3. Submit original receipts and documentation to 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.
- 4. For reimbursement of services already paid, you'll need to provide proof of payment (i.e. paid receipt or copy of cancelled cheque—both sides). Note that claims for expenses must be received by ASEBP within 18 months from the date of service in order to be eligible.

A. Covered member information				
Last name:	First name:	Date of birth: YYYY	//DD	
Mailing address:		Phone number: ()	
	Province:	Postal code:		
Provincial health number:	Group ASEBP ID: 1 9 9 3	Section 0	ID Number	
B. Patient information				
Last name:	First name:	Date of birth: YYYY	//DD	
Provincial health number:	Group ASEBP ID: 1 9 9 3	Section 0	ID Number	
Relationship to covered member:			<u> </u>	
Reason for travel: Business	□ School	YYYY / MM	DD	
□ Treatment Date of departure:	□ Vacation Date of intended ref	turn:/MM_/	DD	
C. Claim information				
Diagnosis:	Have you already p	oaid for this service? Yes	s □ No	
(i.e. reason for treatment) Country claim occurred in: Currency claim occurred in:				
Product or service	Provider of product or service	Date of service (YYYY/MM/DD)	Amount claimed	
□ Ambulance		//		
□ Hospital		//		
☐ Physician services		//		
☐ Prescription drugs		//		
☐ Transportation		//		
☐ Other (e.g. accommodations, car rental, funera	ıl, meals, etc.). Please provide details:			

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If this claim is due to an accident, p	olease complete below:			
Type of accident	Location of accident	Date of accident (YYYY/MM/DD)	Has a claim been made to recover damages from the responsible person(s)?	
			☐ Yes ☐ No	
		//	_ If no, do you intended to make a claim? □ Yes □ No	
D. Other insurance covera	<u> </u>			
Note: This section is only to be co				
Plan name:	Policy number:	l	ID number:	
Last name of coverage holder:	First name of coverage holder:		Date of birth of plan YYYYY MM DD DD	
E Consent for the collectic	on use and disclosure of	norganal informati	on.	
E. Consent for the collection	•	•		
ASEBP, or its Third Party Administrately eligibility of this benefit, verify, ass	ators, Alberta Blue Cross and Ca sess and pay claims and adminis	nAssistance ("Third Party ster your group benefit p	ell as other personal information held by Administrator"), is used to determine lan. It may be necessary for ASEBP and its ealth benefit or insurance companies for	
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.				
to the collection, use and disclosu	re of my personal information for	or the purposes identified	s of providing this information. I consent d above. I understand that I may revoke ' eligibility to receive group benefits.	
I certify that the information contained in this claim and supporting documentation is true, accurate and complete.				
Patient/guardian signature (if patient is a	minor) Covered mer	nber 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 Policy at www.asebp.ca/privacy , 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 <i>Personal Information Protection Act</i> of Alberta and, in relation to personal health information, section 34 of the <i>Health Information Act</i> of Alberta.				

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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

- Personal information and health information that Alberta Health collects and discloses is used for the purposes of payment of benefits to Secondary Insurers, Brokers or Third Party.
- The enclosed Insurance Claim Consent and Authorization form will provide the authority for Alberta Health to assign payments to the secondary insurers, brokers or third party. This means the payment for hospital and physician services the patient receives will be made directly to the secondary insurers, brokers, or third party.
- Authorization for the release of health information and personal 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 to allow for medical service claim(s) processing, and is revocable at any time by the Alberta resident with written notice to the Out-of-Country Claims Unit of Alberta Health.

Form Completion Instructions

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.

Patient Information

- o Name of Patient print the full legal name of the patient who is receiving health services outside of Canada.
- o **Alberta Personal Health Number** (PHN) this is a unique 9-digit number assigned to all Albertans registered with the Alberta Health Care Insurance Plan that appears on the Alberta Health Care card.

Authorization for Release of Health Information

o **Information can be released to** - Write the name of insurance company, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer that is authorized to receive the patient's personal or health information.

Authorization of Payment

- o This allows insurance company, broker or third party who is not an insurer to receive payment from Alberta Health for the health services received by the patient outside of Canada.
- o **Name of payee** write the name of the Payee which is the insurance company, broker submitting on behalf of the insurance company, or third party who is paying for the claims. This authorizes Alberta Health to pay the insurance company, broker or third party directly.

Effective Date

- o The consent is only for the date range provided. **Note**: The patient can change the consent dates at any time by providing written notice to Alberta Health.
- o **Departure Date** The date the patient will leave Alberta to receive the approved health services.
- o **To Date** provide a date that is 18 months past the expected end of treatment date. The healthcare provider has up to 365 days from the date of medical service to submit a claim.

Signature

- By signing, you are declaring that the information provided on the form is true and correct to the best of your knowledge; that you authorize the sharing of the provided personal or health information for the purposes of Alberta Health reimbursing an insurance company, broker or third party for the cost of health services received by the patient while outside of Canada.
- The form **must** be signed by the Alberta resident or a duly legally authorized representative. If the form is signed by a legal representative that person must provide documentation at the time the form is submitted that identifies the specific legal relationship with the Alberta resident that allows that person to sign this form on behalf of the Alberta resident. Any documents submitted to show the legal representative's authority must be notarized copies. Notwithstanding any documentation submitted by a legal representative Alberta Health may request further confirmation as to the legal representative's authority to sign this form on behalf of the Alberta resident.

Submission

- o Return a completed consent to your secondary insurance provider.
- o This form must accompany the insurance claim.

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Insurance Claim Consent and Authorization

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

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.

Patient Information			
	Albert	ta Personal Health Number (PHN)	
Name of Patient - please p			PHN of Patient
Authorization for Release of Health I	nformation		
My health information can be released to:			
		he Alberta School Employee Ben-	
Name of insurance company, and where applicating insurer (e.g. junior hockey clubs, churches).	ole, the name of a broker submitting	g on behalf of the insurance company, or t	third party who is not an
to permit Alberta Health for reimbursement of party which I received outside of Alberta.	of health benefits paid on my be	ehalf for the cost of insured health ser	rvices by the insurer or third
Authorization of Payment			
l,	hereby assign to	CanAssistance	e Inc.
Name of Patient		Name of Pay	/ee
any amounts payable to me by Alberta Heal	th for out of country health ben	efits.	
Effective Date			
This consent is effective From Date (yyyy-	(Departure date)		
ToDate (yyyy-	processing). Please	from the earliest date of service to end note: the submitter has up to 365 day claim to Alberta Health.	
Declaration			
I, the patient, authorize disclosure of the foll- behalf for the cost of insured health services service(s) and reason(s) for service(s), amo personal health number.	s received outside of Alberta, w	hich may include the following: date(s	s) of service(s), type(s) of
I also understand I have been asked to auth insurance company, or third party who is no benefits of consenting, or refusing to conser revocation to the Out-of-Country Claims Uni	t an insurer that has paid a med nt to the disclosure. I further und	dical service claim on my behalf, and	I am aware of the risks and
I, certify that the information provided above	on this form is true and correct	t.	
Please print name of person s	igning	Signature of person completing request or - Signature of authorized representative (is under 18 years of age or wholly der representative by reason of menta	if person completing request pendent on the authorized

legal representative of the resident and must be accompanied by notarized copies of any legal documents that establish to the satisfaction of Alberta Health the individual's legal authorization to sign on behalf of the resident.

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must be a

Please return this completed form to secondary insurance company.

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Insurance Claim Consent and Authorization

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

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.

Patient Information		
	Alberta Per	sonal Health Number (PHN)
Name of Patient - please prir		PHN of Patient
Authorization for Release of Health In	formation	
My health information can be released to:		
Alberta Blue Cı	oss on behalf of the Alberta Scl	nool Employee Benefit Plan
Name of insurance company, and where applicable insurer (e.g. junior hockey clubs, churches).	e, the name of a broker submitting on be	ehalf of the insurance company, or third party who is not an
to permit Alberta Health for reimbursement of party which I received outside of Alberta.	health benefits paid on my behalf f	for the cost of insured health services by the insurer or third
Authorization of Payment		
l,	hereby assign to	Alberta Blue Cross
Name of Patient		Name of Payee
any amounts payable to me by Alberta Health	n for out of country health benefits.	
Effective Date		
This consent is effective From	(Departure date)	
Date (yyyy-m	m-dd)	
To	`processing\ Diseas note:	he earliest date of service to ensure sufficient time for the submitter has up to 365 days from the date of medical to Alberta Health.
Declaration		
behalf for the cost of insured health services	received outside of Alberta, which r	f Alberta Health to reimbursing health benefits paid on my may include the following: date(s) of service(s), type(s) of der(s), and where applicable, the facility name, and
insurance company, or third party who is not	an insurer that has paid a medical s to the disclosure. I further understa	o as to permit Alberta Health to reimburse the identified service claim on my behalf, and I am aware of the risks and and that this consent may be revoked by submitting such
I, certify that the information provided above o	on this form is true and correct.	
Please print name of person sig	ning Signa	ature of person completing request (if 18 years of age and over)
		nature of authorized representative (if person completing request under 18 years of age or wholly dependent on the authorized representative by reason of mental or physical infirmity).

Please return this completed form to secondary insurance company.

If this document is being signed by someone other than the resident or the resident's parent, the individual signing <u>must</u> be a legal representative of the resident and must be accompanied by notarized copies of any legal documents that establish to the satisfaction of Alberta Health the individual's legal authorization to sign on behalf of the resident.

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