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 OUT-OF-COUNTRY 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).
2. 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) / _____ (MM) / ___ (DD)

Mailing address: _____ Phone number: (_____) _____ –_____

City: _____ Province: _____ Postal code: _____

Provincial health number: _____ ASEBP ID: 1 9 9 3 0 (Group) | _____ (Section) | _____ (ID Number)

B. Patient information

Last name: _____ First name: _____ Date of birth: _____ (YYYY) / _____ (MM) / ___ (DD)

Provincial health number: _____ ASEBP ID: 1 9 9 3 0 (Group) | _____ (Section) | _____ (ID Number)

Relationship to covered member: _____ Date of actual return: _____ (YYYY) / _____ (MM) / ___ (DD)

Reason for travel: ☐ Business ☐ School ☐ Treatment ☐ Vacation

Date of intended return: _____ (YYYY) / _____ (MM) / ___ (DD)

Date of departure: _____ (YYYY) / _____ (MM) / ___ (DD)

C. Claim information

Diagnosis: (i.e. reason for treatment) _____ Have you already paid for this service? ☐ Yes ☐ No

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, funeral, meals, etc.). Please provide details: _____

_____

If this claim is due to an accident, please 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 coverage

Note: This section is only to be completed if you have coverage through another insurance plan.

Plan name: _____

Policy number: _____

ID number: _____

Last name of coverage holder: _____

First name of coverage holder: _____

Date of birth of plan member: _____/ _____/ ____ (YYYY / MM / DD)

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 Administrators, Alberta Blue Cross and CanAssistance ("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/guardian signature (if patient is a minor)

_____ Covered member 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 *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

- 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

- **Name of Patient** - print the full legal name of the patient who is receiving health services outside of Canada.
- **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

- **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

- 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.
- **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

- 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.
- **Departure Date** - The date the patient will leave Alberta to receive the approved health services.
- **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

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

Alberta Government

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

Name of Patient - please print

Alberta Personal Health Number (PHN)

PHN of Patient

Authorization for Release of Health Information

My health information can be released to:

Alberta Blue Cross and CanAssistance Inc. 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).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, _____ (Name of Patient) hereby assign to CanAssistance Inc. (Name of Payee)

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From _____ (Date *(yyyy-mm-dd)*) (Departure date)

To _____ (Date *(yyyy-mm-dd)*) (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.

Declaration

I, the patient, authorize disclosure of the following information for the purposes of Alberta Health to reimbursing health benefits paid on my behalf for the cost of insured health services received outside of Alberta, which may include the following: 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.

I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified 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. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

I, certify that the information provided above on this form is true and correct.

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).

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 must 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.

Alberta Government

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.

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Patient Information

Name of Patient - please print

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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).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, _____ (Name of Patient) hereby assign to Alberta Blue Cross (Name of Payee)

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From _____ (Departure date)
Date *(yyyy-mm-dd)*

To _____
Date *(yyyy-mm-dd)*

(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.

Declaration

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I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified 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. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

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