PACIFIC BLUE CROSS™

Emergency Out of Province Claim Form

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1
Street Address
4250 Canada Way
Burnaby, BC

- Please read instructions on reverse before submitting this form. Ensure you have completed all sections.
- Enclose all original receipts. Keep a copy of the receipts for your records.
- For help completing this form, please call us at 604 419-2600 or 1 888 275-4672.

MEMBER INFORMATION

Plan Member's last name	Plan Member's first name	
Plan Member's address	Plan #/Certificate #	ID # (if applicable)
	Postal code	Daytime phone number ( )

CLAIMANTS INFORMATION

	Name of claimant	Birth date (yy/mm/dd)	Personal Health Number (from your Care Card)
1			
2			

Does the claimant have any other coverage which may consider these charges? ☐ Yes ☐ No		Do you or the claimant(s) have a "Gold Credit Card" or any credit cards which may provide travel insurance? ☐ Yes ☐ No Expiry Date:	
Travel insurance name:	ID/policy #	Bank:	ID/Card #/policy #
Extended Health carrier:	ID/policy #	Trust Company:	ID/Card #/policy #
Other coverage:	ID/policy #	Credit Union:	ID/Card #/policy #

Have you claimed or notified any of the above carriers? ☐ Yes ☐ No	If "yes", please indicate the date you notified them (yy/mm/dd)	If "no", please do not claim with them
Country where expenses incurred:		
Date of departure from your province of residence (yy/mm/dd)	Date of return to your province of residence (yy/mm/dd)	
Reason(s) for absence from your province of residence: ☐ Vacation ☐ Student ☐ Sabbatical leave ☐ Moved ☐ Obtain medical treatment ☐ Other (please specify)		
Are injuries the result of a motor vehicle accident? ☐ Yes ☐ No	Is there a person or entity who is liable for your injuries? ☐ Yes ☐ No	
Are you taking legal action against a person or entity? ☐ Yes ☐ No	If "yes", call the Pacific Blue Cross at 604 419-2600 for claiming instructions.	

PLAN MEMBER'S STATEMENT AND CLAIMANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information given on this form is true, correct, and complete to the best of my knowledge. I authorize Pacific Blue Cross to obtain/provide information from/to the provincial medical plan, any doctor, hospital, clinic, person, institution, or other carriers that may have a responsibility in this claim. I also authorize Out of Country Claims, Medical Services Plan, to provide/obtain information to/from the travel insurance or extended health care company that I have named. This is my application for benefits under the Medicare Protection Act and the Hospital Insurance Act.

Assignment of Payment: I authorize Pacific Blue Cross to make payments directly to providers or suppliers for outstanding charges, which are payable benefits under this claim. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to Pacific Blue Cross.

Pacific Blue Cross does not return receipts. Please save our "Explanation of Benefits" for income tax purposes. If you also have coverage with another insurance company, make photocopies of all receipts before sending the originals to Pacific Blue Cross.

X ______________________________
Plan Member's signature Date

X ______________________________
Parent's signature or parent/guardian if claimant is a minor Date

Secure online access to benefit information for Pacific Blue Cross members: **www.pac.bluecross.ca**

CARESNET®

How to claim out of province emergency medical expenses

1. You may claim, under your Pacific Blue Cross plan, charges in excess of the payment made by your **provincial medical plan** (this includes doctors' services, laboratory procedures, hospitalization, radiology and other eligible expenses). In BC, the **provincial medical plan** is **Medical Services Plan of BC (MSP). Pacific Blue Cross will forward your claim to MSP on your behalf.**
2. Complete this form in full (front and back).
3. Complete Schedule "A" and BC Ministry of Health OOC claim form in full. Please note that the person who is 19 and over and incurred the expense(s) must sign the form.
4. Be sure to include the following with your claim: the original itemized/summarized bills and the original receipts showing the bills have been paid in full, **OR** the outstanding itemized/summarized bills so Pacific Blue Cross may consider payment directly to medical provider(s) or supplier(s).
5. Keep copies of bills or receipts for your records.
6. Prior to submitting, all bills or receipts must be translated to English/French.
7. MSP's claiming deadline is 90 days from the date of service. Forms and any supporting documents relating to your claim must be returned to our office as soon as possible in order to meet the MSP deadline.

#	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
1							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
2							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
3							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
4							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
5							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
6							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	

Were you treated by a physician for the above illness/injury prior to your departure? ☐ Yes ☐ No	
If "yes", please specify the condition(s)	
Name of your family doctor	Phone
Family doctor's address	

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SCHEDULE "A"

Assignment of payment due to insured person or beneficiary under the Medical Protection Act or Hospital Insurance Act.

BETWEEN: ___________________________ of the first part, hereinafter referred to as <u>the Assignor</u>
(Enter the patient's name)

AND Pacific Blue Cross of the second part, hereinafter referred to as <u>the Assignee</u>

AND Her Majesty The Queen in the Right of the Province of British Columbia as represented by the Minister of Health hereinafter referred to as <u>the Minister</u>

The Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's ***Medicare Protection Act*** or ***Hospital Insurance Act*** or both, and as such may receive payment for the above services from the Minister.

The Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

In consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _________day of ______________________20___________________________

ASSIGNOR: ___________________________ **WITNESS:**______________________________
(Patient's signature. If the patient is 18 years or younger, a parent or legal guardian's signature is required.) See below *notation. (Signature of someone 19 years or older, other than the Assignor.)

OCCUPATION:_______________________

ASSIGNMENT EFFECTIVE FROM:__________________________TO:________________
(Travel Dates)

THE ASSIGNOR MUST ALSO BE THE ONE WHO SIGNS THE MEDICAL SERVICES PLAN (M. S. P.'S) OUT OF COUNTRY CLAIM FORM.

PLEASE ENSURE ALL SECTIONS OF THIS SCHEDULE A AND M.S.P. OUT OF COUNTRY CLAIM FORM ARE COMPLETED IN FULL AND RETURNED TO OUR OFFICE AS SOON AS POSSIBLE.

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BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY CLAIM
(to be filled out by the beneficiary)

Return to: Medical Services Plan, Out-of-Country Claims
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

IMPORTANT

- **Please read the instructions in Section D before completing this form**
- **Attach all original receipts or bills to this form – include itemized statement (receipts not in English must be translated before being submitted)**
- **Claims must be received within 90 days of the date of service**
- **If you leave Canada specifically to obtain medical care, you must receive prior approval for payment of insured services – see Section D, Elective Services on page 4**
- **This form must be completed and signed by the patient or their legal guardian**
- **Retain copies of bills or receipts for your records**

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME(S)	PERSONAL HEALTH NUMBER (PHN)

BIRTHDATE (DD / MM / YYYY)	GENDER ☐ MALE ☐ FEMALE	HOME PHONE NUMBER	WORK PHONE NUMBER

MAILING ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE

RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / TOWN	PROVINCE	POSTAL CODE

HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC?
☐ YES ☐ NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING

PREVIOUS RESIDENTIAL ADDRESS 1	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)
PREVIOUS RESIDENTIAL ADDRESS 2	**CITY / TOWN**	**PROVINCE**	**POSTAL CODE**	**FROM (MM / YYYY)**	**TO (MM / YYYY)**

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA	EMPLOYER OF ☐ PATIENT ☐ HEAD OF FAMILY

NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)

REASON FOR ABSENCE FROM BRITISH COLUMBIA
☐ VACATION ☐ STUDENT
☐ MOVED ☐ BUSINESS TRIP
☐ OBTAIN MEDICAL CARE ☐ OTHER (SPECIFY):

	MONTH	DAY	YEAR
DATE OF DEPARTURE FROM BC			
DATE OF RETURN TO BC			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? ☐ YES ☐ NO	IF YES, NAME OF COMPANY	POLICY NUMBER

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY?
☐ YES ☐ NO ***If yes, attach statement of payment of claims***

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Out-of-Country Claims, Medical Services Plan, to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the *Hospital Insurance Act* of British Columbia.

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

If legal guardian, provide name and relationship to patient

SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information on this form is collected under the authority of the *Medicare Protection Act* and the *Hospital Insurance Act.* The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown in Section D of the form. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

SECTION B – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)	
TREATMENT / PROCEDURE	DURATION OF ANAESTHESIA _________ HRS _________ MIN OR FROM _________ TO _________
LABORATORY TESTS	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $
SPECIFY EACH AREA X-RAYED	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

*****AMOUNT PAID – ENCLOSE PROOF OF PAYMENT***

#				
1	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
2	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
3	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
4	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
5	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
6	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
7	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO			
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $

SECTION C – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- **In-patient hospital charges include registered bed patient, dialysis, and surgical day care.**
- **Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.**
- **A separate application is required for each admission to hospital.**
- **If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.**

NAME OF HOSPITAL

MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE

ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION

DATE OF ADMISSION:	MONTH	DAY	YEAR	DATE OF DISCHARGE:	MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT?	☐ YES ☐ NO	AMOUNT PAID **(ENCLOSE PROOF OF PAYMENT)** $

ACCIDENTAL INJURY (If hospitalization was the result of an accidental injury, complete this section)

DATE OF ACCIDENT:	MONTH	DAY	YEAR	ACCIDENT LOCATION

TYPE OF ACCIDENT

- ☐ AUTOMOBILE - (YOU WERE):
  - ☐ DRIVER IN TWO/MULTI-CAR COLLISION
  - ☐ PASSENGER IN TWO/MULTI-CAR COLLISION
  - ☐ PEDESTRIAN STRUCK BY AUTOMOBILE
  - ☐ CYCLIST STRUCK BY AUTOMOBILE
  - ☐ DRIVER IN AUTOMOBILE SHOW
  - ☐ PASSENGER IN AUTOMOBILE SHOW
- ☐ OTHER TYPE OF ACCIDENT (SPECIFY):

DESCRIBE HOW THE ACCIDENT TOOK PLACE

WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

NAMES, ADDRESSES AND INSURANCE INFORMATION (IF KNOWN) OF OTHER DRIVERS/PERSONS INVOLVED IN ACCIDENT

1	FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT	
	NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY	POLICY NUMBER
2	FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT	
	NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY	POLICY NUMBER
3	FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT	
	NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY	POLICY NUMBER

SECTION D - GENERAL INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited. For information about coverage, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html

Medical Services Plan (MSP) coverage for emergency out-of-country, physician services is limited to the B.C. physician fee rates.

Provincial coverage for emergency out-of-country, in-patient hospital services is limited to $75.00 CDN per day.

Any difference in fees will be the beneficiary's responsibility.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow 12-16 weeks for processing.

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident plans to leave Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services must be approved by MSP **PRIOR** to leaving BC. Important coverage information and the requirement for medical documentation is detailed on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

MSP DOES NOT PROVIDE COVERAGE FOR THE FOLLOWING:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - employment
  - life insurance
  - immigration purposes
  - school or university
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED *OUTSIDE B.C.* FOR THE FOLLOWING:

- ambulance services
- prescription drugs
- midwife services
- massage therapy
- physical therapy
- naturopathy
- chiropractic
- podiatry
- acupuncture
- optometry
- home care services

DENTAL AND ORAL SURGICAL PROCEDURES

MSP coverage for Dental and Oral surgical procedures is limited to surgery that must be performed in an acute care hospital for patient safety and the medical complexity of the surgery. For detailed coverage information, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/benefits.html#benefits

For more information on submitting an Out-of-Country Claim, visit the Ministry of Health website:
https://www.health.gov.bc.ca/exforms/msp/occ.html

IF YOU REQUIRE FURTHER INFORMATION, CONTACT HEALTH INSURANCE BC AT:

Health Insurance BC
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7
Web: www.hibc.gov.bc.ca

Phone: 604 683-7151 (Lower Mainland)
1 800 663-7100 Toll-free (Rest of BC)
Fax: 250 405-3588

BEFORE MAILING: *Please ensure you have completed your claim form*
Attach all receipts or bills to this form – include itemized statements
Ensure that you have signed all appropriate areas