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CLAIM FORM – TRAVEL INSURANCE

IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you haven't made any payments. Your public health insurance plan covers some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full, but must submit them to your provincial health insurance plan.

In accordance to the terms of your contract, by signing the form you authorize CanAssistance to:

- Access your personal and medical information required to adjudicate your claim
- Pay eligible expenses to service providers directly

Failure to return the duly completed form entitles CanAssistance to ask you to refund the fees paid on your behalf.

Filing a claim

Complete the claim form(s) and sign where designated with an X.

- Each person who received healthcare services must complete a claim form.
- The form must be signed by the beneficiary (person who received healthcare services). If the claim involves a minor, the policyholder must sign the form.

Attach all 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.

We recommend you keep a copy of your claim documents for record-keeping purposes, as they will not be returned.

Send the duly completed forms and all other required scanned documents online via our secure website:

canassistance.com/en/policyholder/depot

We reserve the right to request the original documents up to one year from the date of submission of your claim.

Or send the forms and original claims documents by mail to:

Quebec :
CanAssistance
Travel Claims Department
1981, McGill College Avenue, Suite 400
Montreal, Quebec H3A 2W9

Ontario :
CanAssistance
Travel Claims Department
P.O. Box 4439, Station A
Toronto (Ontario) M5W 3Z4

Additional Information

Your claim will be reviewed as quickly as possible once we've 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 policyholder. If you're covered by more than one travel insurance policy, indicate this on your claim form. We will work with your other insurer 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 us by using the phone number on your insurance card or visit our website at canassistance.com.

01CAN0031A (2023-06)

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TRAVEL INSURANCE CLAIM FORM

CONTRACT NO.

BENEFICIARY INFORMATION (please complete separate form for each person)

PROVINCIAL HEALTH NUMBER	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.	HOME (AREA CODE)	WORK (AREA CODE)

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: X X X X X

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 :

BENEFICIARY'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 BENEFICIARY OR BENEFICIARY'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY — PRINT NAME — DATE

POLICYHOLDER (IF DIFFERENT FROM THE BENEFICIARY)

LAST NAME	FIRST NAME	AGE

PROVINCIAL HEALTH NUMBER: 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 IT ONLINE VIA OUR SECURE WEBSITE **CANASSISTANCE.COM/EN/POLICYHOLDER/DEPOT**

NOTICE: FAILURE TO INDICATE YOUR PROVINCIAL HEALTH INSURANCE NUMBER SHALL RESULT IN THE COMPENSATION BEING REFUSED.

OR BY MAIL TO THE FOLLOWING ADDRESS:
CANASSISTANCE
TRAVEL CLAIMS DEPARTMENT
1981, MCGILL COLLEGE AVENUE, SUITE 400
MONTREAL (QUEBEC) H3A 2W9

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REQUEST FOR PAYMENT BY DIRECT DEPOSIT

IMPORTANT NOTICE

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through the direct deposit option, please complete this form and attach a sample cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Online via our secure website: **canassistance.com/en/policyholder/depot** Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.	*By regular mail :* **CanAssistance, Travel Claims Department** **1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

Policyholder identification

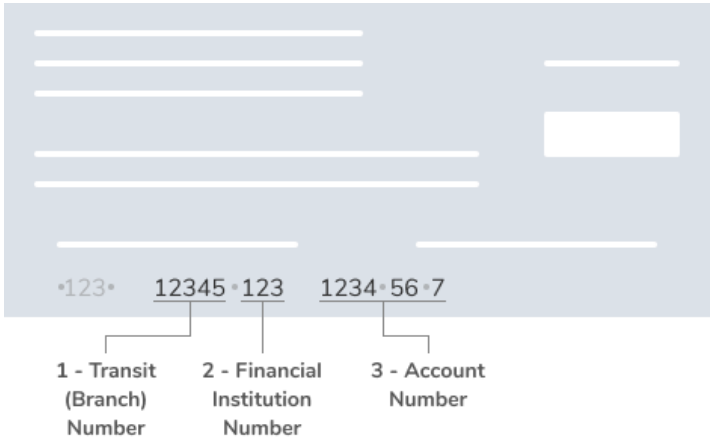
Name of the policyholder	Contract or certificate number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a sample cheque. A copy can also been obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a sample check, please carefully complete the sections below.



Branch number _____

Institution number _____

Account number _____

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of the policyholder _____ Date day / month / year _____

BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE A
ASSIGNMENT OF PAYMENT

Personal Health Number (PHN) of Patient

BETWEEN

Assignor (Adult Patient, or Parent/Guardian of Patient)

AND

Assignee (Insurance Company)	MSP Account Number
CanAssistance	900 32

AND

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter referred to as the Minister.

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

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective from: _____ to _____
(YYYY / MM / DD) *(YYYY / MM / DD)*

_____ _____
Signature of Assignor (Patient or Parent/Guardian of Patient) *Date Signed (YYYY / MM / DD)*

BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE B
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Personal Health Number (PHN) of Patient

Name of Adult Patient, or Parent/Guardian of Patient	Name of Minor-aged Patient (if applicable)

Address	Telephone Number

Insurance Company	
CanAssistance	
Insurance Coverage	
FROM (YYYY / MM / DD)	TO (YYYY / MM / DD)

I, the above-named adult, hereby consent to and authorize the Ministry of Health ("the Ministry") to provide to an authorized representative of the above-named insurance company("the Insurer"), for the use by the Insurer in assessing entitlement to benefits, any and all records and information in the possession of the Ministry regarding claims for medical or health care services incurred while I had insurance coverage with the Insurer during the period noted above, including records and information relating to medical history and physical condition both prior and subsequent to receipt of the medical or health care services.

_____ *Signature of Adult (Patient or Parent/Guardian of Patient)*

Date Signed (YYYY / MM / DD)

BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY MEDICAL CLAIM

IMPORTANT

- This form must be completed and signed by the patient or their legal guardian
- Please read Section B for claim instructions

SECTION A – PATIENT INFORMATION

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

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

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?	IF YES, NAME OF COMPANY	POLICY NUMBER
☐ YES ☐ NO		

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 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 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 is collected under the authority of the *Medicare Protection Act*, the *Hospital Insurance Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering provincial health care benefits. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

SECTION B - GENERAL INFORMATION

CLAIM INSTRUCTIONS

- Attach original receipts and billing invoices to your claim.
- Claims for physician services must be received within 90 days
- Claims for hospital services must be received within 6 months, of the date of discharge
- Receipts and billing invoices not in English or French must include a translation.
- Keep copies of your bills and receipts for your records.

IF YOU HAVE PRIVATE TRAVEL INSURANCE OR AN EXTENDED HEALTH CARE PLAN, CONTACT YOUR TRAVEL PLAN BEFORE SENDING YOUR CLAIM TO HEALTH INSURANCE BC (HIBC).

FOR MORE INFORMATION:

Ministry of Health and HIBC Website: https://www.health.gov.bc.ca/exforms/msp/occ.html

Please check your claim form is complete and signed.

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 **10-12 weeks** for processing.

SEND YOUR CLAIM TO:

HEALTH INSURANCE BC
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

FOR ASSISTANCE, CONTACT:

HEALTH INSURANCE BC
Phone: 604 683-7151 (Lower Mainland), 1 800 663-7100 (Toll-free BC)

PROVINCIAL COVERAGE 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.

Provincial coverage for emergency out-of-country:

- physician services is limited to the B.C. physician fee rates
- dental surgery performed in an acute care hospital (patient safety/medical complexity) is limited to the B.C. oral surgery fee rates
- in-patient hospital services is limited to a daily maximum payment of $75.00 CAN

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

For more information, visit the Ministry of Health website: www.gov.bc.ca/MSPCoverage-LeavingBC

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident leaves Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services **must be requested PRIOR** to leaving BC.

Important coverage information and the requirement for medical documentation is available on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

PROVINCIAL COVERAGE IS NOT PROVIDED FOR:

- 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
  - immigration purposes
  - employment
  - school or university
  - life insurance
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED OUTSIDE B.C. FOR

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

SECTION C – 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 D – 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) $

RESIDENCY INFORMATION

A person must be a B.C. resident to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.; and
- must be physically present in B.C. at least six months in a calendar year, or a shorter prescribed period.*

  * Eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

For more information:
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/eligibility-and-enrolment/are-you-eligible