

AVIS IMPORTANT

Une demande de règlement dûment remplie et signée est essentielle même si vous n'avez rien déboursé. Votre régime public d'assurance santé couvre une partie des frais pour les soins médicaux que vous avez reçus lors de votre voyage. CanAssistance rembourse entièrement ces frais, mais elle doit les soumettre à votre régime provincial d'assurance.

Conformément aux conditions générales du contrat, en signant le formulaire, vous autorisez CanAssistance à :

- accéder à vos renseignements personnels et aux renseignements médicaux pertinents à l'analyse de votre demande de règlement;
- payer directement les fournisseurs de service lorsque les dépenses sont admissibles.

Tout défaut de retourner ce formulaire autorise CanAssistance à vous demander de rembourser les frais qui ont été payés en votre nom.

Faire une demande de règlement

Remplissez la demande de règlement et signez aux endroits désignés par un X.

- Si plusieurs assurés ont reçu des soins médicaux, chaque personne doit remplir un formulaire.
- La demande doit être signée par le bénéficiaire (la personne qui a reçu des services de santé). Si la demande concerne un assuré mineur, elle doit être signée par le titulaire de la police.



Joignez tous les documents suivants:

- Factures originales et détaillées pour tous les services de santé reçus, le diagnostic et le traitement doivent y figurer clairement.
- Reçus originaux pour les médicaments d'ordonnance indiquant le nom du médicament, la posologie et le prix.
- Preuve de paiement pour tous les frais réclamés, tel que la copie d'un relevé de carte de crédit ou une preuve de chèque encaissé indiquant la devise dans laquelle le service a été payé. À défaut de relevé, un reçu de transaction peut être accepté.
- Preuve des dates de votre départ et retour, tel qu'un billet d'avion, de train, une copie du passeport estampillé, un relevé bancaire ou de carte de crédit montrant des achats au Canada juste avant votre départ et immédiatement après votre retour.
- Tout autre document pertinent, tel que rapports médicaux, résultats de laboratoires, etc.



Nous vous recommandons de faire une copie de vos pièces justificatives pour vos dossiers, car ils ne vous seront pas retournés.



Transmettez les formulaires dûment remplis et vos documents numérisés via notre site sécurisé :

canassistance.com/fr/assures/depot

Nous nous réservons le droit d'exiger les documents originaux jusqu'à un an suivant le dépôt de la réclamation.

Vous pouvez également envoyer les documents originaux par la poste à :

CanAssistance
Service des Règlements Voyage
CP 3888, succursale B
Montréal (Québec) H3B 3L7

Informations supplémentaires

Votre réclamation sera analysée dans les meilleurs délais suivant la réception des documents. Toutefois, certains aspects pourraient entraîner des retards dans le traitement de votre réclamation :

- toute demande incomplète ou des documents manquants;
- retard ou difficulté à obtenir une facture détaillée;
- retard ou difficulté à obtenir des renseignements médicaux.

Les dépenses admissibles sont remboursées en devise canadienne par chèque libellé au titulaire de la police. Si vous êtes couvert par plus d'une police d'assurance voyage, indiquez-le sur votre formulaire de réclamation. Nous ferons la coordination des bénéfices avec l'autre assureur au besoin.

Si vous recevez une facture, ne faites aucun paiement directement au fournisseur à moins d'instructions contraires de notre part. Veuillez nous envoyer toutes les factures reçues à l'adresse indiquée ci-dessus.

Si vous avez des questions, vous pouvez communiquer avec nous au numéro d'assistance apparaissant sur votre carte d'assurance ou visitez notre site internet à l'adresse suivante : canassistance.com.

AVIS IMPORTANT

Si votre demande de remboursement est admissible, par défaut un chèque sera émis au titulaire du contrat. Si vous préférez recevoir votre paiement par dépôt direct, veuillez remplir ce formulaire et joindre un spécimen de chèque.

Le versement des prestations par dépôt direct est un service sans frais et est avantageux à plus d'un égard :

- Vous évitez les délais des services postaux et les risques de perte.
- Les fonds virés à votre compte de banque ne sont pas retenus - contrairement à ceux déposés par chèque - et peuvent être retirés dès qu'ils sont déposés.

ENVOYER CE FORMULAIRE DÛMENT REMPLI AINSI QUE TOUS LES AUTRES DOCUMENTS REQUIS À CANASSISTANCE

Via notre site sécurisé :

canassistance.com/fr/assures/depot

Envoyez tous les documents numérisés et conservez les originaux. Nous nous réservons le droit d'exiger les documents originaux jusqu'à un an suivant le dépôt de la réclamation.

Par la poste :

CanAssistance, Service des Règlements Voyage
CP 3888, succursale B, Montréal (Québec) H3B 3L7

Identification du titulaire

Nom complet du titulaire

N° de contrat, certificat ou identification

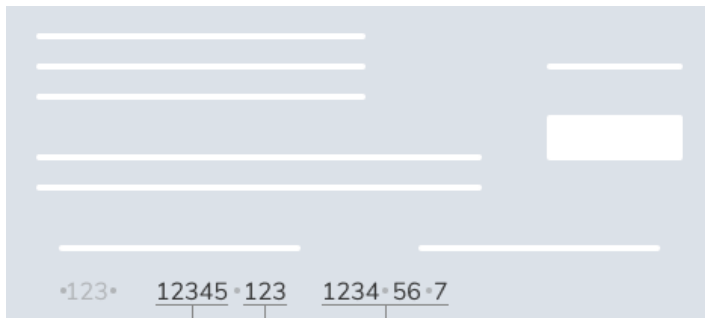
N° De dossier

Renseignements bancaires (Institutions financières canadiennes seulement)

Pour éviter des erreurs et des délais dans le paiement, veuillez joindre un spécimen de chèque. Il est aussi possible d'obtenir un spécimen de chèque en utilisant les services bancaires en ligne de votre institution financière.

Numérisez le document ou prenez-le en photo, en vous assurant que tous les renseignements sont lisibles.

Si vous n'êtes pas en mesure de fournir un spécimen de chèque, veuillez compléter attentivement les sections ci-dessous.



N° de transit

N° d'institution

N° de compte

1 - Numéro
de transit
(succursale)

2 - Numéro
d'institution
financière

3 - Numéro
de compte

Je demande que mes prestations soient versées par transfert électronique de fonds (dépôt direct) dans ce compte.

Signature du titulaire

Date



Personal Health Number (PHN) of Patient

BETWEEN

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

AND

Assignee (Insurance Company) CanAssistance MSP Account Number 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:

(YYYY/MM/DD)

to

(YYYY/MM/DD)

Signature of Assignor (Patient or Parent/Guardian of Patient)

Date Signed (YYYY/MM/DD)



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)



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 <input type="checkbox"/> MALE <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING							
PREVIOUS RESIDENTIAL ADDRESS 1				CITY / TOWN		PROVINCE POSTAL CODE	
PREVIOUS RESIDENTIAL ADDRESS 2				CITY / TOWN		PROVINCE POSTAL CODE	
NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA						EMPLOYER OF <input type="checkbox"/> PATIENT <input type="checkbox"/> 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						MONTH DAY YEAR	
<input type="checkbox"/> VACATION		<input type="checkbox"/> STUDENT		DATE OF DEPARTURE FROM BC			
<input type="checkbox"/> MOVED		<input type="checkbox"/> BUSINESS TRIP		DATE OF RETURN TO BC			
<input type="checkbox"/> OBTAIN MEDICAL CARE		<input type="checkbox"/> OTHER (SPECIFY):					
DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, NAME OF COMPANY			POLICY NUMBER	
ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY? <input type="checkbox"/> YES <input type="checkbox"/> 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/info/ben/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
 - school or university
 - immigration purposes
 - life insurance
 - employment
 - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED OUTSIDE B.C. FOR

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

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