BRITISH COLUMBIA **Ministry of Health Services**

OUT-OF-COUNTRY CLAIM FORM

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

IMPORTANT ➢ ***Completion of this claim form is essential***

- ➢ *Claims **must** be received **within 90 days** of the date of service*
- ➢ *Attach **all original receipts or bills** to this form. Include **itemized statement***
- ➢ *Retain copies of bills or receipts for your records*
- ➢ *Receipts not in English **must be translated** before being submitted*
- ➢ *Form **must be signed** by patient or legal guardian*
- ➢ *Refer to Section D on the back before completing this form*

Personal information on this form is collected under the authority of the *Medicare Protection 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 at the end 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 A - PATIENT INFORMATION

PERSONAL HEALTH NUMBER (ON CARECARD) | DATE OF BIRTH *Month* *Year* | SEX ❒ MALE ❒ FEMALE

NAME OF PATIENT (FAMILY NAME) | GIVEN NAMES | TELEPHONE NUMBER Home: Work:

POSTAL ADDRESS
Number and Street or Box No. | City / Town | Province | Postal Code

RESIDENTIAL ADDRESS OF PATIENT (*If different from above*)
Number and Street | City / Town | Province | Postal Code

HAS PATIENT LIVED AT ABOVE ADDRESS 6 MONTHS PRECEDING DEPARTURE FROM B.C.? ❒ YES ❒ NO *If No, provide residential address(es) where patient was living*

Number and Street	City / Town	Province	Postal Code	From *Month* *Year*	To *Month* *Year*

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA OF ❒ PATIENT OR ❒ HEAD OF FAMILY *(Check appropriate box)*
Name | Address

NAME OF A PERSON *(not a relative)* WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA
Name *(in full)* | Address *(include Postal Code)*

REASON FOR ABSENCE FROM BRITISH COLUMBIA
❒ VACATION ❒ OBTAIN MEDICAL CARE ❒ BUSINESS TRIP
❒ MOVED ❒ STUDENT ❒ OTHER *(specify):*

	Month	*Day*	*Year*
DATE OF DEPARTURE FROM B.C.			
DATE OF RETURN TO B.C.			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? ❒ YES ❒ NO | NAME OF COMPANY | POLICY NUMBER

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

RELEASE OF INFORMATION

The information on this form is collected under the authority of the Medicare Protection Act (R.S.B.C.1992, c. 76) and the Hospital Insurance Act (R.S.B.C.1979, c.180)

I _____ hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information
Name of patient
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 (for in-patient hospital charges).

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

X _____ _____
Patient's Signature *Date*

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

THE REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)	
TREATMENT / PROCEDURE	DURATION OF ANAESTHETIC ________ Hrs. ________ Min. ***or*** From: To:
LABORATORY TESTS	CHARGE $
SPECIFY EACH AREA X-RAYED	CHARGE $

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

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.*
- *Entitlement for hospital benefits is dependent upon residency and it is therefore essential that Sections A and C be completed in the fullest possible detail.*
- ***A separate application is required for each admission to hospital for which a claim is made.***
- *The information requested in this form refers specifically to the person hospitalized. In the case of a dependent child it is necessary to supply particulars of the residence of the head of family.*
- *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	HOSPITAL ADMISSION NUMBER
POSTAL ADDRESS OF HOSPITAL	DATE OF ADMISSION *Month* *Day* *Year*
	DATE OF DISCHARGE *Month* *Day* *Year*

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

HAVE YOU PAID THE HOSPITAL ACCOUNT? ❒ NO ❒ YES, *Enclose proof of payment*

WAS THIS ADMISSION TO HOSPITAL THE RESULT OF AN ACCIDENTAL INJURY? ❒ NO ❒ YES, *Complete the following*

DESCRIBE HOW ACCIDENT TOOK PLACE *(Give names of other persons involved and details of their insurance, if any)*

DATE OF ACCIDENT	ACCIDENT LOCATION	WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

WHERE HOSPITALIZATION IS THE RESULT OF A **MOTOR VEHICLE ACCIDENT,** COMPLETE THE FOLLOWING

IF **TWO-CAR** COLLISION GIVE:

A. FULL NAME AND ADDRESS OF **OTHER** DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE A **PEDESTRIAN** OR **CYCLIST** STRUCK BY AN AUTOMOBILE GIVE:

A. FULL NAME AND ADDRESS OF DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE IN AN AUTOMOBILE SHOW WHETHER YOU WERE ❒ DRIVER OR ❒ PASSENGER, IF PASSENGER GIVE:

A. FULL NAME AND ADDRESS OF DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

ICBC CLAIM NUMBER *(if applicable)*	SIGNATURE
	X

Where a beneficiary receives in-patient hospital services for accidental injuries received as a result of the wrongful act or omission of some other person, the amount of benefits is reduced by the amount of any settlement or award received by the beneficiary in respect of the cost of such hospital services from the person alleged to have been responsible for causing the injuries.

SECTION D - GENERAL INFORMATION

The Medical Services Plan insures out of province medical services required on an emergency basis during a temporary absence and claims must be submitted **within 90 days** from the date of service.

The plan pays for medically required treatment by a qualified **Doctor (M.D.)** up to B.C. rates, any difference in fees is the beneficiary's responsibility.

In-patient hospital benefits are provided to eligible British Columbia residents who are taken ill or are accidentally injured outside British Columbia.

Payment can be made directly to the doctor/hospital. The beneficiary will be reimbursed if the account has been paid.
In instances where there is a small amount payable or the facility/doctor does not accept Canadian currency, payment may be made to the patient. The facility/doctor will be advised of such payments and the patient is responsible for payment of the account.

Please allow 12-16 weeks for processing.

ELECTIVE SERVICES If the beneficiary wishes to seek medical attention outside the province, ***prior authorization*** must first be obtained from the Medical Services Plan through the Medical Advisor before seeking service and before the service is rendered.

ADDITIONAL BENEFITS NOT COVERED OUTSIDE THE PROVINCE

- Chiropractic
- Naturopathic Physicians
- Optometry
- Special Nursing
- Physiotherapy
- Massage Therapy
- Podiatry
- Victoria Order of Nursing

THE FOLLOWING ARE NOT INSURED BENEFITS

- Certified Physician Assistant
- Registered Nurse Practitioner
- Ambulance charges
- Prosthesis and Appliances
- Frames, Eyeglasses and Contact Lenses
- Care in Health Spas and similar facilities
- Nurse anaesthetist
- Drugs
- Transportation, Accommodation expenses
- Supplies
- Use of the Emergency Room
- Medical care at the request of a third party
  (i.e. Insurance, School Admission Examinations, Driver's License, and treatment for which the Workers' Compensation Board, Department of Veteran's Affairs, or other Government agency is responsible)

DENTAL AND ORAL SURGICAL PROCEDURES

Dental and Oral surgical procedures are included as benefits ***only*** when medically required to be performed in a hospital where the insured person is admitted as an in-patient or as a patient under Day Care Surgical services.

FOR FURTHER INFORMATION WRITE:

Victoria Office

Ministry of Health Services
Medical Services Plan
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7

Phone: (250) 952-2654
Fax: (250) 952-2964

BEFORE MAILING:

Please ensure that all areas of the claim form are complete

Attach all receipts or bills to this form. Include itemized statements

Ensure that you have signed all appropriate areas