BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY MEDICAL CLAIM

NOTICE: This form needs to be completed in full an incomplete form will be returned and will thus delay the processing of your claim

IMPORTANT

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

All Sections with an asterisk must be completed on the attached version of this form if applicable

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):

Please ensure that these dates match those on the Schedule A Form >

	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 * In this section please add "RBC Insurance Company of Canada"

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 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.

SIGNATURE OF PATIENT / LEGAL GUARDIAN *

DATE SIGNED *

If legal guardian, provide name and relationship to patient *

NAME OF LEGAL GUARDIAN | CONTACT PHONE NUMBER

RELATIONSHIP TO PATIENT

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. *

Please be aware of the requirements for required documentation as listed, missing documentation will delay the processing of your claim!

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) *

In this section please write: "Please see attached bills and medical reports"

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

In this section please write: "Please see attached bills and medical reports"

MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE

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

	MONTH	DAY	YEAR		MONTH	DAY	YEAR			
DATE OF ADMISSION:				DATE OF DISCHARGE:				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