MANITOBA BLUE CROSS®

TRAVEL HEALTH CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM

- PLEASE ATTACH ORIGINAL ITEMIZED RECEIPTS/INVOICES TO THIS FORM. RECEIPTS/INVOICES WILL NOT BE RETURNED. **RETAIN A COPY OF YOUR CLAIM.**
- ATTACH DOCUMENTATION SHOWING DEPARTURE AND RETURN DATE OF TRIP. (EXAMPLES: TRAVEL ITINERARY, AIRLINE TICKET, CAR RENTAL, GAS RECEIPT)
- WHENEVER POSSIBLE, MANITOBA BLUE CROSS WILL COORDINATE YOUR CLAIM WITH YOUR PROVINCIAL HEALTH PLAN.
- MANITOBA RESIDENTS MUST COMPLETE THE **OUT-OF-COUNTRY MEDICAL AND HOSPITAL SERVICES** SECTION.
- SUBMIT YOUR CLAIM AS SOON AS POSSIBLE. DELAYED SUBMISSION MAY RESULT IN LOSS OF CLAIM PAYMENT.

DECLARATION

- I authorize Manitoba Blue Cross to collect, use and disclose my personal information and personal health information as described on this form.
- I understand it is an offense to make a false or misleading statement in a claim for benefits and declare the answers to the questions below are true and complete.
- I understand that Manitoba Blue Cross requires all documentation before my claim will be adjudicated. Missing information can result in delayed adjudication or denial of my claim.
- I understand it is my responsibility to submit a complete claim, and that I am responsible for any fees related to the completion.

I have read the above and agree

_____ _____

Signature of Member or Patient (or parent/guardian) **Date (dd-mm-yyyy)**

MEMBER'S IDENTIFICATION

Name (last, first) _____ Birth Date (dd-mm-yyyy)_____ Gender ❑ Male ❑ Female

Mailing Address (street/box number, city, province, postal code)_____

Phone (include area code)_____ Email Address_____

Blue Cross Policy/Client Number_____ **Other travel insurance coverage:** (other than Blue Cross) ❑ Yes ❑ No

Additional Blue Cross Coverage? ❑ Yes ❑ No Insurer (company)_____

Policy/Client Number_____ Person Insured_____

Policy/Client Number_____

Provincial Health Care Plan: Provider Name_____

Plan Registration Number_____ Personal Health Identification Number_____

TRAVEL INFORMATION (attach document showing departure and return date of trip)

Date of Departure (dd-mm-yyyy)_____ Date of Return (dd-mm-yyyy)_____

Reason/purpose for travel?_____

MEDICAL INFORMATION of PATIENT (Service Recipient)

Name of your family physician_____ Phone (include area code)_____

Physician's Address_____

What is the cause of your condition? ❑ illness ❑ accident ❑ occupational accident/ilness* ❑ vehicle accident*

**If your claim is related to the above, please attach a copy of the claim made to the relevant organization*

Location of medical attention received during travel_____

Describe reason for seeking medical attention

Diagnosis_____

Symptoms_____

For an accident, provide: Date (dd-mm-yyyy)_____ Time (am/pm)_____ Location _____

Cause/Circumstance_____ Name of Lawyer_____ Police report ❑ No ❑ Yes If yes, attach copy

OUT-OF-COUNTRY MEDICAL AND HOSPITAL SERVICES

Residents of Manitoba

Please complete Schedule 'A' and 'B' below, and return this to Manitoba Blue Cross to ensure prompt assessment of your claim. Completion of this form will allow Manitoba Blue Cross to co-ordinate benefits directly with Manitoba Health (Provincial Health Plan). This form will be returned if not completed in full.

Schedule 'A' **Assignment of Payment due to Registrant under the Health Services Insurance Act**
Schedule 'B' **Authorization to Release Medical Information**

I, _____,

(OR, I,_____ parent/guardian of_____, a minor),
(please print name of parent/guardian) (please print name of patient)

hereby:

'A' Direct Manitoba Health to forward payment to Manitoba Blue Cross for any claim for benefits under the Health Services Insurance Act submitted by Manitoba Blue Cross in respect of medical and hospital services provided outside of Canada, and

'B' Consent to and authorize Manitoba Health to furnish to any representative of Manitoba Blue Cross claim and payment information in Manitoba Health's possession in respect to claims for Medical Services coverage

from_____to_____,
(date of departure) (date of return)

including dates of service, physician/hospital name, and services provided (examples: in-patient, out-patient, physiotherapy, medical visits, procedures, x-ray or laboratory services)

Patient's Manitoba Health Registration Number_____

Patient's Personal Health Identification Number_____

Address_____
(street/box-number, city, province, postal code)

Phone_____
(include area code)

Manitoba Blue Cross Policy and/or Certificate Numbers_____

I have read the above and agree

_____ _____
Signature of Patient (or parent/guardian of minor) **Date (dd-mm-yyyy)**

HOW TO SUBMIT YOUR TRAVEL HEALTH CLAIM

In Person/By Drop Box
599 Empress Street
Winnipeg, Manitoba

By Mail
Manitoba Blue Cross
Case Management Services/Travel
PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

Questions - Travel Claim Only
204.788.6890 in Winnipeg
1.800.873.2583 in Manitoba
1.888.596.1032 outside Manitoba

AUTHORIZATION & CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.