



## DOCUMENTATION REQUIREMENTS

### EMERGENCY MEDICAL CLAIMS FOR TRAVELLING CANADIANS QUEBEC RESIDENTS

Below is a list of required claim forms and additional information, needed to process your recent claim. Please review each item carefully and complete it as accurately and as fully as possible. Be sure to sign each form as indicated. In addition, provide all ORIGINAL receipts, bills and/or prescription receipts.

- Excess Hospital-Medical Claim**
  - Please complete both sides of this form.
  - In Section 3, please remember to sign the bottom of this section, warranting you have disclosed all additional coverages. (Reminder: if information is incomplete or inaccurate, your claim may be null and void)
  - If you list additional coverage in Section 3, you must also sign Section 4.
  
- Power of Attorney & Application for Reimbursement forms**
  - Fully complete and sign both forms (required by Regie).
  - These 2 forms are not required if you are ONLY claiming for any of the following\*:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor, or
    - Prescription glasses replacement, or
    - Additional air travel related benefits

\*Not all policies cover all these benefits—refer to your policy wording to determine if these are covered by your policy.
  
- All ORIGINAL, itemized bills/receipts.**
  
- All ORIGINAL prescription drug receipts** (pharmacy issued tax or customer receipts).
  
- Proof of payment**
  - If you have already paid the medical provider or facility directly, please provide proof of the amount paid so we can process your reimbursement.
  - For example, “paid” receipt from the provider, credit card statement, copy of a cancelled cheque, etc.

- ☑ **Written statement (if your claim is related to an ILLNESS)**
  - Please provide a written statement detailing the diagnosis or the nature of the illness you are claiming for.
  - Wherever possible, please include the dates and times of your consultations, and the name, address and telephone number of the physician/facility that treated you.
  
- ☑ **Written statement (if your claim is related to an INJURY)**
  - Please provide a written description of the event which caused your injury. Be sure to include the date and time of the incident as well as the name, address and telephone number of who you feel is responsible.
  - If possible, please also include the name, address and telephone number of the physician/facility that treated you for the injury.

In the unfortunate event you are filing a claim for someone who has passed away, please also submit:

- ☑ A copy of the Insured's Death Certificate.
  
- ☑ A copy of the section of the Will which designates who will be acting on behalf of the Estate (i.e. who is the Executor).
  
- ☑ The original receipts for cremation or for homeward carriage for burial, if these expenses were incurred while the Insured was travelling.

As we are unable to process your claim until this information is received, please provide all of the requested information as soon as possible.

Thanks for your assistance.

OneWorld Assist looks forward to resolving your claim.



**3. OTHER INSURANCE** (If claimant is a dependent, provide requested information for parents or guardians.)

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan? \_\_\_ Yes \_\_\_ No  
If "Yes", please provide details below:

<u>Name of Insurance Co.</u>	<u>Telephone #</u>	<u>Group Policy#</u>	<u>Member ID#</u>	<u>Lifetime limit</u>
Your employer/retirement plan _____	_____	_____	_____	\$ _____
Spouse's employer/retirement plan _____	_____	_____	_____	\$ _____
Spouse's name <u>FIRST NAME</u> _____ <u>FAMILY NAME</u> _____		Spouse's date of birth <u>M</u>   <u>D</u>   <u>Y</u>		

Do you have benefits available through any other travel insurance company or travel supplier? \_\_\_ Yes \_\_\_ No If "Yes", please provide:

Name of other provider \_\_\_\_\_ Policy # \_\_\_\_\_

Address of other provider \_\_\_\_\_

Did you use a credit card for any of your travel arrangements? (many credit cards offer travel benefits) \_\_\_ Yes \_\_\_ No If "Yes", please provide:

Name of issuing financial institution \_\_\_\_\_

Card number \_\_\_\_\_ Expiry date \_\_\_\_\_

FIRST NAME \_\_\_\_\_ FAMILY NAME \_\_\_\_\_ **X** \_\_\_\_\_ M | D | Y  
 Name of cardholder (please print) Cardholder signature (if different from insured) Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

**X** \_\_\_\_\_ FIRST NAME \_\_\_\_\_ FAMILY NAME \_\_\_\_\_ M | D | Y  
 Signature (claimant or authorized representative) Print name Date

**4. CLAIMANT'S ASSIGNMENT OF PAYMENT**

I assign to OneWorld Assist Inc. ("OWA") any benefits obtainable from other sources for covered losses. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to OWA.

A copy of this authorization received from OWA shall be as effective and valid as the original.

FIRST NAME \_\_\_\_\_ FAMILY NAME \_\_\_\_\_  
 Print full name (and relationship if not claimant)

**X** \_\_\_\_\_ M | D | Y  
 Signature (claimant or authorized representative) Date

**X** \_\_\_\_\_ M | D | Y  
 Signature of primary policy holder of other insurance in Section 3 above ( if applicable) Date



# Regie Power of Attorney

Claim No.

I, THE UNDERSIGNED, \_\_\_\_\_ empower OneWorld Assist Inc.

1. to submit to the *Régie de l'assurance-maladie du Québec (Régie)*, in accordance with the laws and regulations applied by the *Régie*, my claims for insured medical and hospital services which I, my spouse or my children received (family insurance) in \_\_\_\_\_ during our stay there from \_\_\_\_\_ to \_\_\_\_\_;
2. to transmit to, and receive from, the *Régie* all information and documents required for the assessment and payment of said claims;
3. to receive from the *Régie* all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the *Régie* to accept the claims so submitted, to act in accordance with this Power of Attorney as specified and to transmit to the company any information it may request concerning the beneficiary status of myself, my spouse or my children.



\_\_\_\_\_  
Beneficiary's signature

\_\_\_\_\_  
Beneficiary's Health Insurance Number

APPLICATION FOR REIMBURSEMENT

Before completing this form, refer to the Régie's pamphlet entitled *Healthcare Services Covered Outside Québec*, or visit our website at [www.ramq.gouv.qc.ca](http://www.ramq.gouv.qc.ca)

FOR OFFICE USE

CHECK THE APPROPRIATE BOX

Healthcare services received:  
 in Canada  outside Canada

APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER		LAST NAME		LAST NAME (AS APPEARING ON HEALTH INSURANCE CARD)			
LETTERS	NUMBERS	FIRST NAME		DATE OF BIRTH		SEX	
				YEAR	MONTH	DAY	<input type="checkbox"/> M <input type="checkbox"/> F
1 HOME ADDRESS IN QUÉBEC							
NO.		STREET		APT.	LOCALITY		
PROVINCE		POSTAL CODE		PHONE NUMBER AT HOME AREA CODE	PHONE NUMBER AT WORK AREA CODE		
2 ADDRESS FOR CORRESPONDENCE OR PAYMENT, IF DIFFERENT THAN ADDRESS 1							
NO.		STREET		APT.	LOCALITY		
PROVINCE OR STATE AND COUNTRY		POSTAL CODE		PHONE NUMBER AT HOME AREA CODE	PHONE NUMBER AT WORK AREA CODE		
REIMBURSEMENT CHEQUE TO BE MAILED TO:				INQUIRIES TO BE SENT TO:			
<input type="checkbox"/> ADDRESS 1		<input type="checkbox"/> ADDRESS 2		<input type="checkbox"/> ADDRESS 1		<input type="checkbox"/> ADDRESS 2	

PERIODS OF TIME SPENT OUTSIDE QUÉBEC

Period during which you received healthcare services						If you spent other periods of more than 21 consecutive days outside Québec during the calendar year (January 1 to December 31), please specify:																	
Date of departure from Québec			Date of return to Québec																				
YEAR	MONTH	DAY	Year	Month	Day	1st PERIOD			Date of departure			Date of return											
			<input type="checkbox"/> ACTUAL DATE	<input type="checkbox"/> PLANNED DATE		Year	Month	Day	Year	Month	Day	2nd PERIOD			Date of departure			Date of return					
REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)						Year			Month			Day			Year			Month			Day		
<input type="checkbox"/> Vacation or seasonal absence						Year			Month			Day			3rd PERIOD			Date of departure			Date of return		
<input type="checkbox"/> Work Employer's name: _____						Year			Month			Day			Year			Month			Day		
<input type="checkbox"/> Studies Attach a written attestation from the educational institution showing the beginning and end dates of your courses, unless you have already done so.						Year			Month			Day			Year			Month			Day		
<input type="checkbox"/> Receipt of healthcare not available in Québec Régie's authorization number _____						Year			Month			Day			Year			Month			Day		
<input type="checkbox"/> Permanent move <input type="checkbox"/> Within Canada <input type="checkbox"/> Outside Canada Date of move _____						Year			Month			Day			Year			Month			Day		
<input type="checkbox"/> Other Specify _____						Year			Month			Day			Year			Month			Day		

HEALTHCARE SERVICES RECEIVED

Give the reason for which you received these healthcare services

IN THE CASE OF AN ACCIDENT, SPECIFY THE TYPE OF ACCIDENT

Automobile  Work  Other (specify) \_\_\_\_\_

Date of accident: Year Month Day

Describe the services received (examinations, x-rays, surgery, etc.). If you need more space, use a separate sheet.

WHERE DID YOU RECEIVE THESE SERVICES?

LOCALITY: \_\_\_\_\_ CANADIAN PROVINCE OR U.S. STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

If applicable, indicate the number of days you were hospitalized: \_\_\_\_\_

REIMBURSEMENT

Amount claimed: \_\_\_\_\_ Canadian dollars  Other currency  SPECIFY: \_\_\_\_\_

Have you paid the bills?  No  Yes  In full  In part

AMOUNT PAID (enclose originals of receipts): \_\_\_\_\_

SUPPORTING DOCUMENTS

If you did not have travel insurance when you received the services, send all required documents to the Régie.

If you did have travel insurance when you received the services, check whether your insurance company will apply to the Régie for a reimbursement on your behalf.

If so, send all required documents to the insurance company.

If not, send all necessary documents to the Régie.

NAME OF INSURANCE COMPANY: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

SIGNATURE AND AUTHORIZATION

I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or institution any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CSST with a copy of any documents I may send to or receive from the Régie.

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT: \_\_\_\_\_

RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN, ETC.): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Year Month Day

LANGUAGE OF CORRESPONDENCE:  ENGLISH  FRENCH

# Application for Reimbursement

You have **one year** from the date the services were provided to apply for a reimbursement for the cost of medical, dental or optometric services and **three years** for hospital services.

To apply, complete one form per person and indicate the person's Health Insurance Number.

In the case of a child under 12 months of age who has not yet received a Health Insurance Card, indicate the child's last name, first name, date of birth and sex, and enter the father's or mother's Health Insurance Number.

# Supporting Documents

Please submit the **originals of your bills**.

The following must appear clearly:

- the name, address and signature of the health professional who rendered the services;
- the name and address of the facility where the services were provided, and signature of the authorized person;
- a detailed description of the services received;
- the date of and the fees for each service.

Send the **summary of your medical record** if you were hospitalized, and the **operative report** if you had major surgery.

Provide the **originals of your receipts**, e.g. credit card slips. In addition, you can attach **photocopies** of both sides of cashed **cheques** that show the name of the hospital or health professional.

Neither the originals nor photocopies of documents are returned by the Régie.

## MAILING ADDRESS

Send the *Application for Reimbursement* and all required supporting documents to:

Régie de l'assurance maladie du Québec  
Service de l'application  
des programmes (Q037)  
PO Box 6600  
Québec (Québec) G1K 7T3

## FOR FURTHER INFORMATION

Go to our website at:

[www.ramq.gouv.qc.ca](http://www.ramq.gouv.qc.ca)

You may also obtain information by calling.

**In Québec City**  
4 18 646-4636

**In Montréal**  
5 14 864-3411

**Elsewhere in Québec**  
1 800 561-9749

**By TDD**  
*(telecommunication device for the deaf)*  
4 18 682-3939 (in Québec City)  
1 800 361-3939 (elsewhere in Québec)

### By mail

Régie de l'assurance maladie du Québec  
PO Box 6600  
Québec (Québec) G1K 7T3

### Opening hours

Monday, Tuesday, Thursday  
and Friday: 8:30 a.m. to 4:30 p.m.  
Wednesday: 10:00 a.m. to 4:30 p.m.

Outside our opening hours, our office phone numbers connect you to an automated information system.

*Ce document est aussi disponible en français.*

# Application for Reimbursement

## Healthcare Services Covered Outside Québec

