ONEWORLD ASSIST

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.

ONEWORLD ASSIST

This form will be returned if not completed in full

10th Floor, 6081 No. 3 Road • Richmond, BC V6Y 2B2
Telephone: 604 278 4108 • Fax: 604 276 4593
Canada & USA Toll Free: 1 800 663 0399

Excess Hospital-Medical Claim

Claim No. _____

Important Reminders:

- Complete all sections of the claim form(s) in full (front and back), signing where indicated.
- Include original, itemized bills, indicating dates and costs of all services provided.
- Keep copies of all bills for your records.
- By submitting this claim form, you warrant that all information provided is true, correct and complete.
- Your provincial health plan is your primary coverage. Most provincial plans have a 90-day deadline for claiming; if you fail to meet the submission deadline for your provincial plan, you will be responsible for the amount that your provincial plan would have paid.

1. GENERAL INFORMATION

Name of the Insured claiming _____ FIRST NAME _____ FAMILY NAME _____ ❍ M ❍ F

Policy number _____ Date of birth _____ M | D | Y

Address _____ City _____ Prov. _____

Postal code _____ Telephone: Home [ ] _____ Office [ ] _____

E-mail address _____ Fax [ ] _____

Name of provincial health care plan and Personal Health Number _____

Name, address and telephone number of your usual Canadian physician _____

_____

State the names of <u>any</u> medications you were taking prior to departure _____

_____

Departure date from home province _____ M | D | Y Return date to home province _____ M | D | Y

Country where claim occured _____ Currency paid _____

Date Sickness or Injury occurred _____ M | D | Y

Nature and description of Sickness or Injury claimed _____

_____

2. MEDICAL AUTHORITY

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

(This form will be returned to the sender if not completed and signed as indicated.)

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to OneWorld Assist Inc. ("OWA") all information and documentation in their possession that OWA requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records").
2. I authorize OWA to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records is to enable OWA and insurers to assess and determine the eligibility of any claim I might submit. I acknowledge and agree that it is my responsibility to provide to OWA such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act (HIPAA).
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

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

X _____
Signature **(Claimant or authorized representative)**

_____ FIRST NAME _____ FAMILY NAME
name **(and relationship if not claiment)**

M | D | Y
Date

PLEASE COMPLETE AND SIGN REVERSE SIDE

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:

	Name of Insurance Co.	Telephone #	Group Policy#	Member ID#	Lifetime limit
Your employer/retirement plan					$
Spouse employer/retirement plan					$

Spouse's name FIRST NAME FAMILY NAME Spouse's date of birth M | D | Y

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 _____

Credit card number _____

FIRST NAME FAMILY NAME — Name of cardholder (please print)

X _____ — Cardholder signature (if different from insured)

M | D | Y — Date

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

X _____ — Signature (claimant or authorized representative)

FIRST NAME FAMILY NAME — Print name

M | D | Y — 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_____ — Signature (claimant or authorized representative)

M | D | Y — Date

X_____ — Signature of primary policy holder of other insurance in Section 3 above (if applicable)

M | D | Y — Date

ONEWORLD ASSIST

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10th Floor, 6081 No. 3 Road • Richmond, BC V6Y 2B2
Telephone: 604 278 4108 • Fax: 604 276 4593
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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

Régie de l'assurance maladie Québec

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**

FOR OFFICE USE

CHECK THE APPROPRIATE BOX ▶ Healthcare services received: ☐ in Canada ☐ outside Canada

APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER (LETTERS / NUMBERS)

LAST NAME

LAST NAME (AS APPEARING ON HEALTH INSURANCE CARD)

FIRST NAME

DATE OF BIRTH (YEAR / MONTH / DAY)

SEX ☐ M ☐ 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: ☐ ADDRESS 1 ☐ ADDRESS 2

INQUIRIES TO BE SENT TO: ☐ ADDRESS 1 ☐ ADDRESS 2

PERIODS OF TIME SPENT OUTSIDE QUÉBEC

Period during which you received healthcare services

Date of departure from Québec (YEAR / MONTH / DAY)

Date of return to Québec ☐ ACTUAL DATE ☐ PLANNED DATE (Year / Month / Day)

REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)

☐ **Vacation or seasonal absence**

☐ **Work** — Employer's name: .....

☐ **Studies** — Attach a written attestation from the educational institution showing the beginning and end dates of your courses, unless you have already done so.

☐ **Receipt of healthcare not available in Québec** — Régie's authorization number .....

☐ **Permanent move** — ☐ Within Canada ☐ Outside Canada — Date of move (Year / Month / Day)

☐ **Other** — Specify .....

If you spent other periods of more than 21 consecutive days outside Québec during the calendar year (January 1 to December 31), **please specify:**

1st PERIOD

Date of departure (Year / Month / Day)	Date of return (Year / Month / Day)

2nd PERIOD

Date of departure (Year / Month / Day)	Date of return (Year / Month / Day)

3rd PERIOD

Date of departure (Year / Month / Day)	Date of return (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 sent 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 more detailed information, visit our website.

www.ramq.gouv.qc.ca

FOR FURTHER INFORMATION

Go to our website at:

www.ramq.gouv.qc.ca

You may also obtain information by calling.

In Québec City
418 646-4636

In Montréal
514 864-3411

Elsewhere in Québec
1 800 561-9749

By TDD
(telecommunication device for the deaf)
418 682-3939 (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.

Régie de l'assurance maladie Québec

RÉGIE DE L'ASSURANCE MALADIE DU QUÉBEC

Application for Reimbursement

Healthcare Services Covered Outside Québec

Québec