MANITOBA BLUE CROSS®

TRAVEL HEALTH CLAIM FORM

PLEASE READ CAREFULLY BEFORE COMPLETING THE FORM

- PLEASE ATTACH 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 patient (or parent/guardian of a minor) _____ **Date (dd/mm/yyyy)** _____

PATIENT'S IDENTIFICATION (Service Recipient)			
Name (last, first)	Birth Date (dd/mm/yyyy)	Age	☐ Male ☐ Female
Mailing Address (street/box number, city, province, postal code)			
Phone Number (include area code)	Email Address		
Should we have questions, what is your preferred method of contact?			
Manitoba Blue Cross Policy/Certificate Number	**Other travel insurance coverage:** (other than Blue Cross) ☐ Yes ☐ No		
Additional Manitoba Blue Cross Coverage ☐ Yes ☐ No	Insurer (company)		
Policy/Certificate Number	Person Insured	Policy/Certificate Number	
Provincial Health Care Plan: Provider Name			
Plan Registration Number	Personal Health Identification Number		
Reminder: Manitoba residents must also complete the OUT-OF COUNTRY MEDICAL AND HOSPITAL SERVICES section on page 2			
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?			

PATIENT'S MEDICAL INFORMATION (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/illness* ☐ 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

Date of first symptoms of illness or injury: (dd/mm/yyyy)

Has the patient experience this illness or similar symptoms before? ☐ Yes ☐ No If 'Yes', when? (dd/mm/yyyy)

For an accident, provide: Date (dd/mm/yyyy)	Time (a.m./p.m.)	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 coordinate benefits directly with Manitoba Health, Seniors and Active Living (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, Seniors and Active Living 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, Seniors and Active Living to furnish to any representative of Manitoba Blue Cross claim and payment information in Manitoba Health, Seniors and Active Living'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, Seniors and Active Living 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 a minor) **Date (dd/mm/yyyy)**

STATEMENT OF EXPENSES (complete one statement per patient)

Patient's Last Name	Patient's First Name	Policy/Certificate Number

Service Provider	Service Date (dd/mm/yyyy)	Amount Claimed	Currency	Payment Recipient Please check one ✓ (Provider)	(You)
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
TOTAL					

AUTHORIZATION & CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the 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 or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. 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 and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross's privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

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

A photostatic copy of this authorization shall be as valid as the original.

HOW TO SUBMIT YOUR CLAIM

Electronically: *Employer Travel Coverage*
Submit through mybluecross® at mb.bluecross.ca

Personal Travel Coverage (Deluxe, Annual, Tour Package)
Email Travel_claims@mb.bluecross.ca

Mail: PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

In Person/ Drop Box: 599 EmpressStreet
Winnipeg, MB

Fax: 204.788.5591

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