EMERGENCY MEDICAL EXPENSE
PSHCP CLAIM FORM

Please complete, sign and return promptly to Allianz Global Assistance.
Without this information, we are unable to proceed with your claim.

P.O. Box 277
Waterloo, Ontario
N2J 4A4

or

P.O. Box 71987
Richmond, VA USA
23255-1987

PATIENT INFORMATION

Patient Name: ____ Case: - ______________

Address: ______________________ City: __________ Province: __________ Postal Code: __________

E-mail: ______________________________ Can we contact you via: Phone / E-mail? (circle preference)

Patient's Date of Birth: ____________ (MM/DD/YYYY) Gender ☐ M ☐ F Patient's Relationship to PSHCP Member: ______________

Patient's Provincial Health Card Number: ____________________ version code (for some Ontario residents) ____________

PSHCP Member Information (if different from patient)

Member Name: ____________________ Certificate No.: __________ Member's Date of Birth: ______________

Have you paid for treatment? ☐ No ☐ Yes Total amount being claimed: $______________

If "Yes", please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page

☐ Partial ☐ Paid in Full (submit proof of payment) Service provider name: ____________________ Amount Pd: __________

☐ Partial ☐ Paid in Full (submit proof of payment) Service provider name: ____________________ Amount Pd: __________

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TRAVEL DETAILS

Departure Date: ____________ (MM/DD/YYYY) Anticipated/Scheduled Date of Return: ____________ (MM/DD/YYYY) Actual Return Date: ____________ (MM/DD/YYYY)

Nature of Travel: ☐ Business ☐ Vacation ☐ Study ☐ Medical Care ☐ Other: __________ Destination: ______________

Mode of Travel: ☐ Car ☐ Airplane ☐ Other: ________ If applicable, was Extension of Coverage purchased? ☐ No ☐ Yes (specify)

OTHER INSURANCE INFORMATION FOR COORDINATION OF BENEFITS

Employer Information
If retired, specify name of employer providing benefits:

Employer Name: ______________________ Retired? ☐

Address: ______________________________

Phone: ______________________________

Spouse's Name: ______________________________

Spouse's Date of Birth: ____________ (MM/DD/YYYY)

Spouse's Employer: ____________________ Retired? ☐

Address: ______________________________

Phone: ______________________________

Please indicate all other insurance coverage you have through any other insurer: (i.e. employee/retiree/spousal group benefits, credit cards with insurance benefits, or any other purchased travel plan). Attach an additional page if required.

1) Name of Insurer: ______________________________ Phone: ______________________________

Address: ______________________________ Lifetime payable limit on policy? ☐ No ☐ Yes (specify) $__________

Policy No: __________ Certificate No: ______________ Signature of Policyholder: ______________________

SEE REVERSE FOR PAGE 2

2) Name of Insurer: ____________________ Phone: ____________________

Address: ____________________ Lifetime payable limit on policy? ☐ No ☐ Yes (specify) $__________

Policy No: __________ Certificate No: __________ Signature of Policyholder: ____________________

Credit Card Insurance coverage: include card type and bank: ____________________ Number:____________________

Have you submitted these bills to any of the above insurance companies? ☐ No ☐ Yes If yes, which company? ____________________

RELEVANT MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

____

____

Were medical services required as result of an accident? ☐ Yes ☐ No If "Yes", please provide details and include an accident report with this form.

____

____

Name of Hospital: ____________________ Date of Occurrence: ____________________

Have you had any of these symptoms/conditions before? ☐ Yes ☐ No If "Yes", indicate the date you were last treated: ____________________

AUTHORIZATION

SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to AZGA Service Canada Inc., doing business as Allianz Global Assistance, directly and I hereby release GHIP, upon payment to AZGA Service Canada Inc. from any further claim or cause of action in connection herewith.
I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out-of-country services (pursuant to Section 39 (1) of the Freedom of Information and Privacy Act, and for Ontario residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act).
I consent to the disclosure by GHIP, including OHIP, to AZGA Service Canada Inc. of such personal information[1] including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information however, if I do so my claim cannot be processed and paid.
In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to AZGA Service Canada Inc. or, if directed by AZGA Service Canada Inc., to the insurance company underwriting the policy for which such payment was made.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

Keeping your information confidential

At all times, the information collected will be protected under the provisions of the Personal Information Protection and Electronic Documents Act (PIPEDA)

By signing below, I certify that all goods and/or services being claimed have been received by me, my spouse or my eligible dependant children. I certify that, to the best of my knowledge, the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan. I also certify that all claimants on this form continue to meet the PSHCP eligibility requirements. I acknowledge and agree that the terms of my Positive Enrolment "Consent to release of personal information" apply to this claim.

I hereby authorize AZGA Service Canada Inc. its agents and service providers to collect, use and disclose information about me, my spouse and my dependants to other persons and organizations including health professionals who have, or require, relevant personal information about me, my spouse and my dependants pertaining to this claim for the purposes of determining any insurance coverage relevant to the adjudication of my claim for out-of-country health services, administration purposes, and underwriting purpose.

I understand that I may withhold my consent to the collection, use and disclosure of such information; however, if do so my claim cannot be processed and paid. I agree that a photocopy or facsimile of this authorization shall be as valid as the original and that this authorization shall be considered valid for the duration of this claim. I understand information about me may be reviewed in the event that this plan is audited.

Keeping your information confidential

At all times, the information collected will be protected under the provisions of the Personal Information Protection and Electronic Documents Act (PIPEDA)

Member Signature Date (mm-dd-yyyy)

Name of Patient (Please print): ____ Date: ______________________________
MM/DD/YYYY

Canadian Address: ____

Signature of **Patient / Designated Legal Proxy** *: ____ Phone No: __________________

Signature of **PSHCP Member**: ____ Date: ______________________________
MM/DD/YYYY

* If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix, etc.) please provide proof of "Legal Representative" status.

When sending original documents, be sure to keep a copy for your records.
If you have questions, please call us at 1-800-363-1835. Our Customer Service Team can help.