WORLD ACCESS

GREEN SHIELD CANADA

EMERGENCY MEDICAL EXPENSE CLAIM FORM

Please complete, sign and return promptly to World Access
Without this information, we are unable to proceed with your claim.

P.O. Box 277
Waterloo, ON Canada
N2J 4A4

or

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

PATIENT INFORMATION

Patient Name: _____ Case # _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Patient's Date of Birth: _____ (MM/DD/YEAR) ☐Male ☐Female Patient's Relationship to Policyholder: _____

Patient's Provincial Health Card Number *(including version code for residents of Ontario)*: _____

Insurer's Information

Policyholder Name: _____

Policyholder's Date of Birth: _____ (MM/DD/YEAR) World Access Group #: _____ Green Shield I.D. #: _____

TRAVEL DETAILS

Was this your 1st trip outside your home province this year? ☐Yes ☐No, this was my _____ stay outside my home province this year.

Departure Date: _____ (MM/DD/YEAR) Anticipated/Scheduled Date of Return: _____ (MM/DD/YEAR) Actual Return Date: _____ (MM/DD/YEAR)

Nature of Travel: ☐Business ☐Vacation ☐Study ☐Medical Care ☐Other: _____

OTHER INSURANCE INFORMATION (if applicable, include spousal information for co-ordination 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/YEAR)

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, enhanced credit cards, personal property such as home/auto 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 #: _____ Certificate #: _____ Signature of Policyholder: _____

2) Name of Insurer: _____ Phone: _____

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

Policy #: _____ Certificate #: _____ Signature of Policyholder: _____

If trip purchased by **Credit Card**, specify card name: _____ Number: _____ Expiry: _____

Have these bills been filed with any other company? ☐No ☐Yes If yes, name and contact info: _____

Additional documentation that IS REQUIRED (check if including)

- ☐ Original, itemized medical bills and prescription receipts if received by patient
- ☐ Photocopy of patient's Provincial Health Card

Additional documentation that MAY BE REQUIRED

- ☐ Accident Report (if applicable)
- ☐ Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)
- ☐ Proof of Departure (envelope enclosed if required by your plan)

MEDICAL INFORMATION – (Complete only if you did not contact World access at the time of medical emergency)

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 or treating facility: _____ Date of Occurrence: _____
MM/DD/YEAR

Have you had any of these conditions before? ☐Yes ☐No

_____

Date medications **last** changed **before** your departure (includes type and dosage): _____
MM/DD/YEAR

Name, Address and Phone # of your Family Physician: _____

Last medical visit (in Canada) before your trip? _____ Country where claim occurred: _____
MM/DD/YEAR

Have you paid for treatment? ☐Yes ☐No If "Yes", please specify: ☐Partial or ☐Paid in Full and submit proof of payment

Total amount being claimed: $_____ Currency: _____

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 World Access Canada directly and I hereby release GHIP, upon payment to World Access Canada 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 Protection of 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 World Access Canada of such personal information 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 World Access Canada or, if directed by World Access Canada, to the insurance company underwriting the policy for which such payment was made.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with World Access Canada or its representatives any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

I authorize any other insurance carrier to release and exchange with World Access Canada or its representatives any medical or benefits payment information relating to this claim.

I understand that if I am a dependant under this plan, the policyholder will have access to information about me related to this claim in connection with administration of this plan.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): _____ Date: _____
MM/DD/YEAR

Canadian Address: _____

Signature of Patient / Designated Legal Proxy *: _____ Phone #: _____

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires 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.