SOUMETTRE UNE DEMANDE DE RÈGLEMENT

VOICI LES ÉTAPES POUR SOUMETTRE UNE DEMANDE DE RÈGLEMENT

Étape 1 . . . .Rassembler toutes vos factures originales détaillées.

Étape 2 . . . .Remplir et signer la *Demande de règlement.*

Étape 3 . . . .Remplir et signer le formulaire d'assurance maladie de votre province de résidence.

Étape 4 . . . .Fournir une preuve de la date de départ de votre province de résidence, si vous soumettez une demande de règlement sous un Plan Annuel.

LISTE DE CONTRÔLE

Avez-vous :

- ☐ Rempli et signé la *Demande de règlement* ?
  Tout formulaire incomplet sera retourné et retardera le traitement de votre réclamation.
- ☐ Joint l'ensemble des factures originales ?
  Les photocopies ne sont pas acceptées.
- ☐ Rempli et signé le formulaire d'assurance maladie de votre province ?
  Tout formulaire incomplet sera retourné et retardera le traitement de votre réclamation.
- ☐ Joint une preuve de votre date de départ de votre province de résidence (si vous soumettez une demande de règlement sous un Plan Annuel) ?
- ☐ Conservé une copie pour vos dossiers ?

NOTES IMPORTANTES

- Les documents ci-haut mentionnés doivent être reçus dans les 90 jours suivant votre retour de voyage.
- Les factures sous forme de coupon de caisse ne seront pas considérées aux fins de remboursement.
- Les frais additionnels pour toute documentation de support sont sous votre responsabilité.

ENVOYEZ L'ENSEMBLE DE VOS DOCUMENTS À :

La Survivance-Voyage
Att : Département des réclamations
247, boul. Thibeau
Trois-Rivières (Québec) G8T 6X9

Pour un suivi de votre réclamation

Sans frais : 1-800-268-9633
Courriel : suivireclamation@tourmed.ca

WWW.TOURMED.CA
Téléphone : 1 800 268-9633
Télécopieur : 1 819 377-6069

247, boul. Thibeau
Trois-Rivières (Québec) G8T 6X9

DEMANDE DE RÈGLEMENT

Assuré par
La Survivance Voyage

**Ce formulaire est nécessaire,
que vous ayez payé des frais vous-même ou non.**

Ce formulaire de réclamation doit être rempli, signé et retourné à nos bureaux, au plus tard, 90 jours suivant votre retour dans votre province de résidence.

Si vous éprouvez des difficultés à remplir ce formulaire, notre Service des réclamations est disponible pour répondre à toutes vos questions du lundi au vendredi de 8 h 30 à 17 h 00. Composez sans frais le 1 800 268-9633 ou à frais virés le 819 377-1777.

VEUILLEZ INCLURE LES DOCUMENTS PERTINENTS SUIVANTS

- Les factures originales détaillées ou les reçus originaux détaillés
  - ✓ Notez que les photocopies ou coupons de caisse ne sont pas acceptés
  - ✓ **La franchise de 5 $ US par ordonnance N'EST PAS REMBOURSABLE**
- **Une preuve*** de la **Date de départ** de votre province de résidence est requise pour toute réclamation sous le **PLAN ANNUEL**
  *(carte d'embarquement, billet d'avion, reçu de carte de crédit ou confirmation obtenue aux douanes/immigration).

DÉCLARATION DE L'ASSURÉ(E)

Nom et adresse de l'assuré(e) où le remboursement doit être expédié.

_____ _____
Prénom Nom # de police

_____
No Rue # app. Ville Province Code postal

_____ Téléphone : (_____) _____ Date de naissance : _____ / _____ / _____
No d'assurance maladie jj mm aa

Je souhaite être remboursé en : CAN ☐ USD ☐

Possédez-vous une autre assurance voyage privée (groupe, retraité, Medicare, carte de crédit) ? OUI ☐ NON ☐

Compagnie : _____ N° de police : _____ Téléphone : (_____) _____

DÉPENSES ENGAGÉES

Inscrire les détails et les montants de vos dépenses. (S'il vous faut plus d'espace, veuillez utiliser une feuille séparée.)

Nom du fournisseur des services médicaux (ou tout autre type de frais engagés)	Date du service reçu jj/mm/aa	Montant de la facture	Montant payé par vous	Devise
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

1. RÉCLAMATION POUR FRAIS MÉDICAUX (RÉPONDRE À TOUTES LES QUESTIONS)

a) S.v.p., cocher les cases pertinentes : Maladie ☐ Accident ☐ Autre ☐ Spécifiez : _____

b) Soins reçus : En cabinet/clinique ☐ En salle d'urgence d'un hôpital ☐ Lors d'une hospitalisation ☐

c) S.v.p., veuillez fournir les dates et un résumé des détails reliés à cette réclamation.

_____

_____

_____

_____

d) Dans le passé, avez-vous été soigné(e) pour ces symptômes ou maladies : OUI ☐ NON ☐

Si OUI, s.v.p., veuillez fournir les dates et endroits de consultation.

_____

_____

2. RÉCLAMATION POUR ALLER-RETOUR D'URGENCE (Section à remplir uniquement si applicable.)

Dans tous les cas, veuillez soumettre les reçus originaux pour le transport aérien incluant une photocopie des cartes d'embarquement.

Réclamation pour :
- ☐ **Décès** (veuillez soumettre un certificat de décès ou rapport médical indiquant la cause du décès, résidents du Québec : le formulaire SP3 est requis)
- ☐ **Hospitalisation** (veuillez soumettre un certificat médical indiquant la raison de l'admission ainsi que les dates d'admission et de congé)
- ☐ **Sinistre** à votre domicile ou place d'affaires (veuillez soumettre les documents justificatifs tels que rapport de police, confirmation de votre assureur privé)

Montant réclamé pour le transport aérien : _____ $

Nom du membre de votre famille immédiate _____ Date de naissance _____ Lien de parenté _____

Adresse de cette personne _____

Date d'admission à l'hôpital _____ Date du congé _____ Raison de l'admission _____

Date du décès _____ Cause du décès _____ Endroit où le décès a eu lieu _____

Dans les 6 mois précédant la date de votre départ initial, est-ce que cette personne :

A été hospitalisée ? ☐ OUI ☐ NON Si OUI, dates et nom de l'hôpital : _____

Souffrait d'une maladie en phase terminale ? ☐ OUI ☐ NON

Résidait dans un centre de soins longue durée/CHSLD ? ☐ OUI ☐ NON

Si OUI, indiquez le nom et l'adresse de ce centre/CHSLD : _____

AUTORISATION ET ATTESTATION

Par les présentes, je cède à Tour+Med/La Survivance-Voyage, compagnie d'assurance (l'Assureur) toute indemnité pouvant provenir d'autres sources pour les frais couverts par la présente police d'assurance. Je demande également à ces sources de faire parvenir à l'Assureur tout versement à l'égard de ma demande de règlement relativement à ces sinistres et les autorise à échanger des renseignements pour faciliter le processus.

J'autorise tout médecin, hôpital, autre professionnel de la santé, autre établissement de soins, sociétés d'assurance et toute autre personne qui m'a soigné ou examiné ainsi que toute autre source impliquée dans cette réclamation à communiquer à l'Assureur des renseignements médicaux me concernant ou tout autre renseignement nécessaire dans l'administration de cette réclamation. Je consens également à ce que l'Assureur communique ces renseignements à d'autres sources en vue de procéder à la coordination des prestations, le cas échéant.

Je certifie que je ne bénéficie d'aucune autre assurance que celles mentionnées dans ce formulaire de demande de règlement.

Je comprends que le fait de faire des déclarations erronées ou trompeuses relativement à une demande de règlement entraînera l'annulation de la police d'assurance.

J'atteste que les renseignements fournis à l'égard de la présente demande de règlement sont, à ma connaissance, vrais, complets et exacts.

Une photocopie, un fac-similé ou une copie électronique de la présente autorisation est aussi valable que l'original.

Signature de l'assuré : _____ Date : _____

BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY MEDICAL CLAIM

IMPORTANT

- This form must be completed and signed by the patient or their legal guardian
- Please read Section B for claim instructions

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME(S)	PERSONAL HEALTH NUMBER (PHN)

BIRTHDATE (DD / MM / YYYY)	GENDER	HOME PHONE NUMBER	WORK PHONE NUMBER
	☐ MALE ☐ FEMALE		

MAILING ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE

RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / TOWN	PROVINCE	POSTAL CODE

HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC?

☐ YES ☐ NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING

PREVIOUS RESIDENTIAL ADDRESS 1	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)
PREVIOUS RESIDENTIAL ADDRESS 2	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA	EMPLOYER OF
	☐ PATIENT ☐ HEAD OF FAMILY

NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)

REASON FOR ABSENCE FROM BRITISH COLUMBIA

☐ VACATION ☐ STUDENT
☐ MOVED ☐ BUSINESS TRIP
☐ OBTAIN MEDICAL CARE ☐ OTHER (SPECIFY):

	MONTH	DAY	YEAR
DATE OF DEPARTURE FROM BC			
DATE OF RETURN TO BC			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE?	IF YES, NAME OF COMPANY	POLICY NUMBER
☐ YES ☐ NO		

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY?

☐ YES ☐ NO ***If yes, attach statement of payment of claims***

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Medical Services Plan to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Medical Services Plan to provide/obtain information to/from the above named travel insurance or extended health benefits company.

_____

In addition, my signature below is my Application for Benefits under the *Hospital Insurance Act* of British Columbia.

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

	If legal guardian, provide name and relationship to patient	
SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information is collected under the authority of the *Medicare Protection Act*, the *Hospital Insurance Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering provincial health care benefits. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

SECTION B - GENERAL INFORMATION

CLAIM INSTRUCTIONS

- Attach original receipts and billing invoices to your claim.
- Claims for physician services must be received within 90 days
- Claims for hospital services must be received within 6 months, of the date of discharge
- Receipts and billing invoices not in English or French must include a translation.
- Keep copies of your bills and receipts for your records.

IF YOU HAVE PRIVATE TRAVEL INSURANCE OR AN EXTENDED HEALTH CARE PLAN, CONTACT YOUR TRAVEL PLAN BEFORE SENDING YOUR CLAIM TO HEALTH INSURANCE BC (HIBC).

FOR MORE INFORMATION:

Ministry of Health and HIBC Website: https://www.health.gov.bc.ca/exforms/msp/occ.html

Please check your claim form is complete and signed.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow **10-12 weeks** for processing.

SEND YOUR CLAIM TO:

HEALTH INSURANCE BC
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

FOR ASSISTANCE, CONTACT:

HEALTH INSURANCE BC
Phone: 604 683-7151 (Lower Mainland), 1 800 663-7100 (Toll-free BC)

PROVINCIAL COVERAGE INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited.

Provincial coverage for emergency out-of-country:

- physician services is limited to the B.C. physician fee rates
- dental surgery performed in an acute care hospital (patient safety/medical complexity) is limited to the B.C. oral surgery fee rates
- in-patient hospital services is limited to a daily maximum payment of $75.00 CAN

Any difference in fees will be the beneficiary's responsibility.

For more information, visit the Ministry of Health website: www.gov.bc.ca/MSPCoverage-LeavingBC

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident leaves Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services **must be requested PRIOR** to leaving BC.

Important coverage information and the requirement for medical documentation is available on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

PROVINCIAL COVERAGE IS NOT PROVIDED FOR:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - immigration purposes
  - employment
  - school or university
  - life insurance
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED OUTSIDE B.C. FOR

- ambulance services
- massage therapy
- naturopathy
- podiatry
- optometry
- prescription drugs
- physical therapy
- chiropractic
- acupuncture
- home care services
- midwife services

SECTION C – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	DURATION OF ANAESTHESIA _____ HRS _____ MIN OR FROM _____ TO _____
LABORATORY TESTS	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $
SPECIFY EACH AREA X-RAYED	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

*****AMOUNT PAID – ENCLOSE PROOF OF PAYMENT***

1	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
2	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
3	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
4	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
5	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
6	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $
7	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM
			AMOUNT PAID** $

SECTION D – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- In-patient hospital charges include registered bed patient, dialysis, and surgical day care.
- Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.
- A separate application is required for each admission to hospital.
- If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.

NAME OF HOSPITAL									
MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE									
ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION									
DATE OF ADMISSION:	MONTH	DAY	YEAR	DATE OF DISCHARGE:	MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT? ☐ YES ☐ NO	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

RESIDENCY INFORMATION

A person must be a B.C. resident to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.; and
- must be physically present in B.C. at least six months in a calendar year, or a shorter prescribed period.*

  * Eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

For more information:
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/eligibility-and-enrolment/are-you-eligible

BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE A
ASSIGNMENT OF PAYMENT

Personal Health Number (PHN) of Patient

BETWEEN

Assignor (Adult Patient, or Parent/Guardian of Patient)

AND

Assignee (Insurance Company)	MSP Account Number
LS TRAVEL INSURANCE COMPANY	900 39

AND

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter referred to as the Minister.

WHEREAS the Assignor is a person eligible for insured services and/or benefits under the Province of *British Columbia's Medicare Protection Act* and/or *Hospital Insurance Act*, and as such may receive payment for certain of those services or benefits from the Minister.

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective from: _____ *(YYYY / MM / DD)* to _____ *(YYYY / MM / DD)*

_____ *Signature of Assignor (Patient or Parent/Guardian of Patient)*

_____ *Date Signed (YYYY / MM / DD)*

HLTH 2806 2018/03/15

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