TO SUBMIT A CLAIM

HERE ARE THE STEPS TO SUBMIT A CLAIM

Step 1 . . . . . Gather all your original detailed receipts.

Step 2 . . . . . Complete and sign the *Claim Form*.

Step 3 . . . . . Complete and sign your Provincial Health Insurance Plan form.

CHECKLIST

Have you:

- ☐ Completed and signed the *Claim Form*?
  All incomplete forms will be returned and will delay your claim assessment.
- ☐ Attached all original receipts?
  Photocopies will not be accepted.
- ☐ Completed and signed your Provincial Health Insurance Plan form?
  All incomplete forms will be returned and will delay your claim assessment.
- ☐ Made photocopies for your records?

IMPORTANT NOTES

- All aforementioned documents must be received within 90 days of your return to your province of residence.
- Cash register coupons (stubs) will not be accepted for reimbursement.
- Any fees for the completion of medical certificates or claim forms are your responsibility.
- Make sure to provide legible documents. Photographs and pictures will not be accepted.

SEND ALL YOUR DOCUMENTS TO:

LS-Travel
Att: Claims department
247 Thibeau Boulevard
Trois-Rivières (Quebec) G8T 6X9

To verify your claim status:

Toll free: 1-877-344-8398
Email: claimsfollowup@tourmed.ca

WWW.TOURMED.CA
Telephone : 1 877 344-8398
Fax : 1 819 377-6069

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

CLAIM FORM

Insured by

This claim form is mandatory whether you have incurred out of pocket expenses or not.

This claim form must be completed, signed and returned to the Insurer no later than 90 days after you return to your province of residence. If you need assistance in completing this claim form, our Claims team will answer your questions from Monday to Friday, 8:30AM to 5:00PM EST. Call toll free 1-877-344-8398 or collect 1-819-377-1777.

PLEASE SUBMIT THE APPLICABLE SUBSTANTIATING DOCUMENTATION

- Original detailed invoices or receipts:
  - ✓ Please note that photocopies or cash/cashier receipts are not accepted
  - ✓ **The US $5 co-pay for each prescription is NOT REFUNDABLE**
- **A proof*** of your **Departure date** from your province of residence is mandatory for claims submitted under the **ANNUAL PLAN**
  (* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

CLAIMANT'S STATEMENT

Name of the Insured and address where to send the refund. Desired currency: CAD ☐ USD ☐

_____ _____
First name Last name Policy Number

_____
No. Street apt. # City Province Postal Code

_____ Telephone: (_____) _____ Date of birth : _____ / _____ / _____
Government Health Insurance Number dd mm yy

Are you covered by any other private travel insurance (group, retired, Medicare, credit card)? YES ☐ NO ☐

Company:_____PolicyNumber:_____Telephone:(_____)_____

CLAIM EXPENSES

Provide brief description of the expenses and indicate amounts incurred. (If you need more space, please attach a separate sheet).

Name of medical services provider (or any type of services incurred)	Date of service received (mm/dd/yyyy)	Amount billed	Amount paid by you	Currency
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

1. CLAIM FOR MEDICAL EXPENSES (PLEASE ANSWER ALL QUESTIONS)

a) Please check the appropriate box: Sickness ☐ Accident ☐ Other ☐ Please specify: _____

b) Treatment received in: Office/clinic ☐ Emergency Room of a hospital ☐ Hospital ☐

c) Please provide dates and brief details about this claim.

_____

_____

_____

_____

_____

_____

_____

_____

d) In the past, have you ever been treated for those symptoms or illnesses? YES ☐ NO ☐

If YES, please provide the dates and places of consultation.

_____

_____

_____

_____

_____

_____

2. CLAIM FOR EMERGENCY ROUND TRIP EXPENSES (Section to be filled out only if applicable.)

In all cases, please submit original receipts for air transportation including copy of boarding pass.

Claim for:
- ☐ **Death** (please submit death certificate or medical report indicating cause of death – Quebec residents: SP3 form is required)
- ☐ **Hospitalization** (please submit medical certificate indicating diagnosis, admission and discharge dates)
- ☐ **Disaster** at your principal residence/place of business (please submit substantiating documentation such as police report/private insurance confirmation)

Amount claimed for air transportation: $ _____

Name of the immediate family member	Date of birth	Relationship to you

Complete address of that person

Hospital admission date	Hospital discharge date	Reason of admission

Date of death	Cause of death	Place of death

In the 6 months prior to your departure date, was the person:

Hospitalized? ☐ YES ☐ NO If YES, please indicate dates and name of hospital: _____

Suffering from a terminal illness? ☐ YES ☐ NO

Residing in a long term care facility (CHSLD)/assisted living facility? ☐ YES ☐ NO

If YES, please indicate name and complete address of that facility: _____

CERTIFICATION AND AUTHORIZATION

I hereby assign to LS-Travel, Insurance Company, (hereinafter "Insurer") any benefits obtained from other sources, including but not limited to, insurance companies, airlines, travel agencies, and any other source, for losses covered under this policy. I also direct these sources to transmit payment to the *Insurer* for my claims submitted by the *Insurer* with regard to these losses and authorize all sources and the *Insurer* to communicate all relevant information to facilitate the claims process.

I hereby authorize LS-Travel, Insurance Company, to collect, by any electronic means, email, fax or mail, and to use, any medical or non-medical information about me held by, including but not limited to, any licensed physician, practitioner, hospital or medical institution, insurance company, or any other organization, agency, institution, company or person (hereinafter "Third Parties") who has information or documents relevant to the analysis of any claim submitted under this insurance policy. I understand that this information could also be communicated to these Third Parties, whether in or outside of my province of residence. In the event of a claim, I also authorize the *Insurer* to collect, from my *Representative*, any telephone conversation recorded during the application process.

If, for any reason, I do not authorize LS-Travel, Insurance Company, to collect and use this information, I understand that my benefits could be reduced or limited, according to the terms and conditions of the policy. A photocopy or facsimile of this authorization is accepted and recognized as valid as the original or a true copy thereof.

I declare that I am aware of the rights granted by the "Act Respecting the Protection of Personal Information in the Private Sector", including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

I certify that I have no other insurance coverage than the ones mentioned in this claim form.

I understand that the making of false or fraudulent statements in connection with a claim for benefits will render the insurance policy null and void.

I certify that the statements given in the making of this claim are complete, true, and accurate to the best of my knowledge.

A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and valid as the original or a true copy thereof.

Insured's signature: _____ Date: _____

IMPORTANT NOTES

- Cash register coupons (stubs) will not be accepted for reimbursement.
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7500-160 EN- Rév. 09/2023

Application for Reimbursement - Medicare
Demande de remboursement - Assurance-maladie

Reset / Effacer

Medicare New Brunswick /
Assurance-maladie du Nouveau-Brunswick
P.O. Box / C.P. 5100, Fredericton, NB E3B 5G8
TeleServices toll free / Numéro sans frais de Téléservices : 1-888-762-8600

Patient Name / Nom du patient	N.B. Medicare # / N° d'Assurance-maladie du N.-B.	Telephone N°/ N° de téléphone (H/D) (W/T)	Date of Birth/ Date de naissance D/J M Y/A
Beneficiary (i.e. parent, spouse, guardian)/ Bénéficiaire (p.ex. : parent, conjoint, tuteur)	Date of service/ Date du service D/J M Y/A	Location of service/ Lieu du service ☐ Inpatient/ Hospitalisation ☐ Office/Bureau	☐ Outpatient Department Services ambulatoires ☐ Other/Autre _____
Address / Adresse	Name and address of service provider / medical practitioner if applicable/ Nom et adresse du dispensateur de service / médecin s'il y a lieu		
	Diagnosis (Reason for visit) Le diagnostic (raison de la visite)		

Please note: Original signed invoices or receipts (no faxes, photocopies or carbon copies) must be submitted.

In the case of a claim for reimbursement for services rendered inside the province, no payment shall be made for entitled services unless the account or claim for reimbursement is received by Medicare within six (6) months after the date upon which the entitled services were rendered.

In the case of entitled services rendered outside the province, no payment shall be made for entitled services unless the account or claim for reimbursement is received by Medicare within twelve (12) months after the date upon which the entitled services were rendered.

Veuillez noter : Vous devez soumettre les factures ou reçu originaux signés (les télécopies, photocopies ou les copies carbonées ne sont pas acceptables).

Dans le cas d'une demande de remboursement pour des services rendus dans la province, nul paiement ne peut être effectué pour des services assurés à moins que la facture ou la demande de remboursement n'ait été reçu par l'assurance-maladie dans les six (6) mois qui suivent la date de prestation des services.

Dans le cas de services assurés rendus à l'extérieur de la province, nul paiement ne peut être effectué pour des services assurés à moins que la facture ou la demande de remboursement n'ait été reçue par l'assurance-maladie dans les douze (12) mois qui suivent la date de prestation des services.

I hereby apply for payment in respect of the cost of medical and/or hospital services on behalf of myself or the above named patient and certify that the information which I have given is true and correct.

Je demande par les présentes le paiement des services médicaux et/ou hospitaliers reçus par moi-même ou par le patient précité. Je certifie que les renseignements que j'ai donnés sont véridiques et exacts.

Signature _____ Date _____

The Department of Health is committed to safeguarding your privacy. For more information on our privacy practices and about your rights regarding this issue, go to www.gnb.ca (key word – Privacy Notice).

Le ministère de la Santé est résolu à protéger votre vie privée. Pour plus de renseignements en ce qui a trait à nos pratiques en matière de protection de renseignements personnels, ainsi que de vos droits à ce sujet, consultez le www.gnb.ca (mot clé - Avis sur la protection de la vie privée).

35-3431 (5/12)

Top/Haut

SEND TO:

LS-TRAVEL
247, Thibeau Blvd
Trois-Rivières (Quebec)
G8T 6X9

POWER OF ATTORNEY

I, the undersigned _____
(BLOCK LETTERS)

Empower LS-Travel:

1. To submit to the New Brunswick Medicare, in accordance with the laws and regulations applied by the New Brunswick Medicare, my claims for the insured medical and hospital services which I, my spouse or my children received (family insurance)

in _____
LOCATION

during our stay from _____ to _____
DATE (YYYY-MM-DD) DATE (YYYY-MM-DD)

2. To transmit to and receive from the New Brunswick Medicare all information and documents required for the assessment and payment of the said claims.

3. To receive from the New Brunswick Medicare all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the New Brunswick Medicare to accept the claims submitted, to act in accordance with this Power of Attorney as specified and to transmit to LS-Travel any information regarding the beneficiary status of myself, my spouse or my children.

_____ _____
SIGNATURE HEALTH INSURANCE NUMBER