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 _____

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

Régie de l'assurance maladie Québec

APPLICATION FOR REIMBURSEMENT

Before completing this form, read the reverse side and refer to the information on our website at **www.ramq.gouv.qc.ca**. Click on **Temporary stays outside Québec** under Citizens.

FOR OFFICE USE

CHECK THE APPROPRIATE BOX Healthcare services received: ☐ in Canada ☐ outside Canada

APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER	LAST NAME	LAST NAME AT BIRTH (IF DIFFERENT FROM THE NAME ON THE HEALTH INSURANCE CARD)
LETTERS / NUMBERS	FIRST NAME	DATE OF BIRTH (YEAR / MONTH / DAY) — SEX (M ☐ F ☐)

HOME ADDRESS (see over)

NO. / STREET / APT. / MUNICIPALITY

PROVINCE / POSTAL CODE / PHONE NUMBER AT HOME AREA CODE / PHONE NUMBER AT WORK AREA CODE

PERIODS OF TIME SPENT OUTSIDE QUÉBEC

Period during which you received healthcare services

Date of departure from Québec (Year / Month / Day) | **Date of return to Québec** ☐ ACTUEL DATE ☐ PLANNED DATE (Year / Month / Day)

REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)

- ☐ **Vacation or seasonal absence**
- ☐ **Work** — Employer's name
- ☐ **Studies** — Attach a written attestation from the educational institution showing the beginning and end dates of your courses, unless you have already done so.
- ☐ **Receipt of healthcare not available in Québec** — Régie's authorization number
- ☐ **Permanent move outside Québec** — Date of move (Year / Month / Day)
- ☐ **Other** — Specify

If you spent other periods of **more than 21 consecutive days** outside Québec during the calendar year (January 1 to December 31), please specify:

	Date of departure (Year / Month / Day)	Date of return (Year / Month / Day)
1st PERIOD		
2nd PERIOD		
3rd PERIOD		

HEALTHCARE SERVICES RECEIVED

Give the reason for which you received these healthcare services

IN THE CASE OF AN ACCIDENT, SPECIFY THE TYPE OF ACCIDENT ☐ Automobile ☐ Work ☐ Other (specify) — Date of accident (Year / Month / Day)

Describe the services received (examinations, x-rays, surgery, etc.). If you need more space, use a separate sheet.

WHERE DID YOU RECEIVE THESE SERVICES? MUNICIPALITY	CANADIAN PROVINCE OR U.S. STATE	COUNTRY	**If applicable,** indicate the number of days you were hospitalized:

REIMBURSEMENT

Amount claimed	Canadian dollars ☐	Other currency ☐ SPECIFY:	Have you paid the bills? ☐ No ☐ Yes ☐ In full ☐ In part	AMOUNT PAID **(enclose originals of receipts)**

TRAVEL INSURANCE

Were you covered by travel insurance when you received the services?

☐ No ☐ Yes — NAME OF INSURANCE COMPANY | POLICY NUMBER

SIGNATURE AND AUTHORIZATION

☐ I hereby authorize the Régie de l'assurance maladie du Québec to provide to and receive from my travel insurance company all the information and documents required for the assessment and payment of my claims for insured medical and hospital services that I received and, if applicable, that my spouse or children received (family insurance).

☐ I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or facility any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CNESST with a copy of any documents I may sent to or receive from the Régie.

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT	RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN ETC.)	**SIGNATURE** X	YEAR / MONTH / DAY

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 Régie de l'assurance-maladie du Québec (the Régie), in accordance with the laws and regulations applied by the Régie, 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 Régie all information and documents required for the assessment and payment of the said claims.
3. To receive from the Régie all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the Régie 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