EMERGENCY MEDICAL EXPENSE CLAIM

CCMP
4-160 Pony Drive (2nd floor)
Newmarket ON L3Y 7B6

Toll Free Tel.: 1-866-209-0112
Email: claims@ccmp.ca

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

PATIENT INFORMATION

Patient Name: _____ Policy # _____ Claim # _____

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

Patient's Date of Birth: _____ (MM/DD/YYYY) ☐ Male ☐ Female Email address: _____

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

TRAVEL DETAILS

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

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

Employer Information

If retired, provide name of last employer providing benefits:

Employer Name: _____ Retired? ☐

Address: _____

Telephone: _____

Spouse's Name: _____

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

Spouse's Employer: _____ Retired? ☐

Address: _____

Telephone: _____

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 insurance plan). If necessary, please use an additional page.

1) Name of Insurance Company: _____ Telephone: _____

Address: _____ Does this policy have a lifetime payable limit? ☐ No ☐ Yes (specify) _____

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

2) Name of Insurance Company: _____ Telephone: _____

Address: _____ Does this policy have a lifetime payable limit? ☐ No ☐ Yes (specify) _____

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

3) **If Motor vehicle accident:** Name of Insurance Company: _____ Telephone: _____

Policy #: _____ Certificate #: _____

4) **If trip purchased on Credit Card** please specify name _____ Number: _____ Expiry Date: _____

Have any of these bills been filed with any other company? ☐ No ☐ Yes If Yes, name of company: _____

Telephone: _____ Contact person: _____

***Page 2** of this form must be completed*

Documentation required for this claim: (when submitting original documents, please keep a copy for your records.)

☐ All original, itemized medical bills and prescription receipts if received by patient

☐ Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)

☐ Proof of Departure

☐ Photocopy of the patient's Provincial Health Card

☐ Accident Report (if applicable)

If you have questions, please call us at 1-866-209-0112. Our Claims Service Team can help.

MEDICAL INFORMATION

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

_____

_____

Whether sickness or accident, please describe briefly the situation leading to you seeking medical attention, including the diagnosis.

_____

_____

Name of Hospital/Clinic: _____ Date of Occurrence: _____ MM/DD/YYYY

Did you call our assistance line within 24 hours? ☐ Yes ☐ No Do you have any other claims with us? ☐ Yes ☐ No

Have you had any of these conditions before? ☐ Yes ☐ No If "Yes", indicate the date you were **last** treated: _____ MM/DD/YYYY

Please list all medications in use **before** your departure date: _____

_____

_____

Any medication change **before** your departure date? ☐ Yes ☐ No If "Yes", please provide details: _____

_____

_____

Name, address and phone # of your Family Physician in Canada: _____

Date of your last medical visit in Canada before your trip: _____ MM/DD/YYYY Country where claim occurred: _____

Have you paid for your treatment? (If "Yes", please submit proof of payment): ☐ Yes ☐ No ☐Full ☐ Partial

Total amount being claimed: $ _____ Currency: _____

PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND ASSIGNMENT

I direct and authorize my provincial Government Health Insurance Plan (GHIP), to make a payment in respect of my claim for out-of-country health services to CCMP on behalf of the insurer and I hereby release GHIP, upon payment to CCMP from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP, 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, Section 4(2)(f) of the Health Insurance Act, and the Personal Health Information Protection Act].

I consent to the disclosure by GHIP, to CCMP 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 considered for payment. 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 CCMP.

Insured's Signature: _____ Date: _____ MM/DD/YYYY GHIP #: _____ Include version code (Ontario residents only)

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given 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 CCMP 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 CCMP or its representatives any medical or benefit payments information relating to this claim, and I authorize and direct such payors to forward payment directly to CCMP.
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 dateit is signed. I understand I have a right to receive a copy of this authorization.

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

Canadian Address: _____

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

* 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.

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