# CLAIM AND AUTHORIZATION FORM

Send the original completed claim form and supporting documents to:


**Canadian Address**
Penfield Care, Inc
310-260 Hearst Way
Ottawa, Ontario K2L 3H1

PH 800.705.5991
FAX 613.701.0828

**United States Address**
Penfield Care, Inc
431 State Street - Suite 1235
Ogdensburg, NY 13669

claims@penfieldcare.com
www.penfieldcare.com


## PATIENT INFORMATION-MEDICAL

Last Name _____

First Name _____

Date of Birth _____ (DD/MM/YYYY) Phone # _____

Address (Number & Street) _____

City _____ Province _____ Postal Code _____

Email _____

Relationship to policy holder Same ◯ Spouse ◯ Child ◯

Other (please specify) ◯ _____

## POLICY HOLDER INFORMATION (If different from patient)

Last Name _____

First Name _____

Date of Birth: _____ (D/MM/YYYY) Phone # _____

Address (Number & Street) _____

City _____ Province _____ Postal Code _____

Email _____

## CLAIM DETAILS

Trip Departure Date: _____ Trip Return Date: _____

The date you sought medical attention: _____

The reason for seeking medical attention (diagnosis): _____

If you incurred "out of pocket" expenses and your claim is payable should the cheque be made to patient?

Yes ◉ Claim will be paid out to patient
No ○ Please provide name and address for cheque recipient:

_____

## MEDICAL EXPENSES LIST

| Eligible expenses paid (i.e. prescriptions, Dr. visits, meals, ambulance, etc.) | Date Incurred | Amount | Currency | Original Receipt Enclosed Y/N |
|---|---|---|---|---|
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |

*** If your expenses are in more than one currency, please total each separately & Please attach another sheet if your expenses exceed the space provided**

## REIMBURSEMENT PREFERENCE

Cheque ○ Electronic funds transfer ◉

Associated email for electronic funds transfer _____
Preferred currency CDN ○ USD ◉

## CANADIAN FAMILY DOCTOR AND/OR SPECIALIST INFORMATION

Your medical history may be required to fully review your claim. Please provide your Canadian physician(s) information below:

| PHYSICIAN | | Telephone |
|---|---|---|
| Family Physician | | |
| Walk-In Clinic (if available) | | |
| Canadian Specialist | | |
| Specialist (other) | | |

## OTHER INSURANCE INFORMATION

**1. Please enter your Provincial Health Insurance Plan number (including version code):**

_____

(For Ontario, depending on date OHIP card was issued/renewed, Version Code may be 0/1/2 letters)

**2. Are you or your spouse entitled to benefit under any other plan for the medical expenses being claimed?**

YES ◉ NO ○

If YES, please provide details below: If NO, leave blank and complete the next section:

| INSURANCE | YOU | SPOUSE |
|---|---|---|
| Insurance Company | | |
| Plan Number | | |
| Plan Member ID Number | | |

If spouse plan, please provide spouse's name _____

Date of birth _____ (DD/MM/YYYY)

**3.Do you have a credit card with travel insurance coverage?** YES ◉ NO ○

If YES, please provide detail below: To help you receive all additional payments you are entitled to, we will coordinate with any other potential insurers on your behalf. We will determine if the card provides coverage for your incident.

| CREDIT CARD DETAILS | |
|---|---|
| Name on Card | |
| Card Type | |
| Card Number | |
| Expiry Date | |

**4. Was your Medi-Quote travel insurance purchased as a top up?** YES ○ NO ○

If you answered yes, please provide the following details

| TOP UP COVERAGE DETAILS | |
|---|---|
| Company Name | |
| Policy or Credit Card Number | |
| Date 'Top Up Coverage" went into effect | (DD/MM/YYYY) |

## CONSENT/AUTHORIZATION & RELEASE SPECIFICATIONS

This section provides Penfield Care Inc. authorization to obtain, recover and forward information, payments and/or obtain recovery from your Provincial health insurance plan

**1.Direction and release** I, _____ personally or as the authorized substitute/proxy for (the insured patient) _____ Irrevocably direct and authorize the Provincial Ministry of health and long-term care (The Ministry) to make payment in respect of my claim, or if applicable the insured patient's claim, for out of country health services directly to Penfield Care Inc and hereby release the ministry, upon payment to Penfield Care Inc., from any further claim or cause of action in connection therewith. Note: An authorized substitute/proxy is a person authorized under PHIPA to consent on behalf of an individual to disclose personal health information about the individual.

**2. Consent I authorize the ministry to collect my/the insured patient's personal health information, consisting of:**

● Information relating to my/the insured patient's receipt of health care services outside Canada and

● Information relevant to the reimbursement of those services under the health insurance Act and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my/the insured patient's request for payment under the health insurance act. Including the details of any duplicate payment previously made to me/the insured patient, to Penfield Care Inc. I understand the purpose for the Ministry's collection and disclosure of their personal health information.

You have the right to refuse to sign this consent form, however, Penfield Care Inc and the Ministry will be unable to process your/the insured patient's claim if this form is unsigned.

**3. Authorization My/Insured patient's name** _____

Address _____

Telephone number _____ Other phone _____

Signature _____ Date _____

Witness Name _____

Address _____

Telephone number _____ Other phone _____

Witness signature _____

Date _____

## GENERAL AUTHORIZATION TO RELEASE

1. I assign to Penfield Care Inc. any amount obtainable from other sources for covered losses under this policy. I also direct this source to forward payment to Penfield Care Inc. for my claim submitted by Penfield Care Inc. with regards to these losses and to exchange information that facilitates this process.

2. I authorize any hospital physician or medical facility to send my medical information to Penfield Care Inc. authorized representative of the insured. I further consent to the disclosure of this information by Penfield Care Inc to other sources as may be required to obtain benefit from other sources.

3. I warrant that neither I or any insured person have any additional coverage through any other insurer (other than that listed above)

4. I understand that my insurance shall be void, if whether before or after the loss, any person had concocted or misrepresented any fact or circumstance concerning the claim

Patient or authorized person's signature _____

Date _____