



# Out-Of-Province Hospital/Medical Insurance Claims Information Sheet (Ontario Only)

*This document addresses frequently asked questions related to Out-of-Province Hospital/Medical Insurance claims*

## MEDICAL INJURY / SICKNESS CLAIMS

- The Out-of-Province Insurance Claim Form must be completed in full in order to process your claim. Please be sure to state **your departure and return dates and diagnosis**.
- In the event that the insured was initially seen in a hospital outside Canada, a copy of the *Hospital Discharge Report* must be submitted, if available.
- Claims for **Physiotherapy / Massage Therapy/ Brace expenses** must be accompanied by the original receipts and the written referral from the attending physician recommending physiotherapy treatment.
- Claims for **Brace expenses** must be for therapeutic or curative purposes only.
- Please submit the following documents with the claim form:
  1. **Proof of travel:** copies of airline tickets, accommodation receipts, etc. showing your departure and return dates from/to Ontario.
  2. A copy of your **health card**.
  3. **Original itemized bills and receipts**.
  4. A copy of your **credit card statement** outlining the exchange rate, if expenses were paid for on your credit card.
  5. **\*Ontario Residents Only** - A fully completed **Authorization, Consent & Release form** for the Ontario Ministry of Health. If you did not download the Authorization, Consent and Release form with the Out-of-Province Insurance claim form, please contact the Industrial Alliance Pacific Claims Department at 1-800-266-5667.

## IMPORTANT

- The Out-of-Province Insurance Claim Form must be filed with Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") within 90 days of the date of the injury/illness. Attach only original receipts for all expenses being claimed.
- Please note that it is the responsibility of the claimant to report their claim to us and once the form has been received, to forward the completed claim form as indicated to our office. *Any charge incurred for its completion is also the responsibility of the claimant.*
- If you have more than one insurance carrier, benefits are coordinated.
- In the United States, it is customary for the provider of a particular service to send individual invoices. All such invoices should be forwarded to our office for our review.

## WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED.....

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 1-3 weeks. Our response would be one of the following:
  - (A) *Payment or Notification of Payment to a Provider*
  - (B) *Request for more information if required*
  - (C) *Acceptance or Denial of the claim with reasons*

Return completed claim form to:  
**INDUSTRIAL ALLIANCE PACIFIC INSURANCE AND FINANCIAL SERVICES INC.**  
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6  
Tel: 1-800-266-5667  
[www.iapacific.com](http://www.iapacific.com)

In providing claim forms for the convenience of the claimant, IAP does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.



Claims Department  
Special Market Group  
2165 Broadway West, PO Box 5900  
Vancouver, BC V6B 5H6  
Telephone: 1-800-266-5667  
Fax: 604-733-9519

**AUTHORIZATION, CONSENT AND RELEASE RELATED TO ANY REIMBURSEMENTS OF BENEFITS FROM  
THE ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE  
("THE MINISTRY") PERTAINING TO THIS CLAIM.**

You have incurred out of country/province medical expenses. In the event your claim is eligible for reimbursement from Industrial Alliance Pacific Insurance and Financial Services Inc. ("Industrial Alliance Pacific") you have the option to:

**EITHER**

**Direct and authorize the Ministry to make payment in respect of your claim directly to Industrial Alliance Pacific and release the Ministry upon payment to Industrial Alliance Pacific from any further claim or cause of action in connection therewith and also consent to Industrial Alliance Pacific's disclosing to the Ministry such personal health information as may be required for the purpose of verifying your request for payment under the Health Insurance Act. You do this by signing the Authorization, Release and Consent attached.**

**OR**

**You may refuse to sign the Authorization and Release and Consent sections, but in so doing, Industrial Alliance Pacific is not in a position to proceed directly with your claim. You will be responsible for paying all expenses and submitting applicable expenses to the Ministry yourself. Industrial Alliance Pacific will only consider claims after you have submitted to the Ministry and received reimbursement of the Ministry's portion.**

**IF YOU WISH TO PROCEED, PLEASE READ THE FOLLOWING AUTHORIZATION AND RELEASE.**



AUTHORIZATION, CONSENT AND RELEASE RELATED TO ANY REIMBURSEMENTS OF BENEFITS FROM
THE ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE
("THE MINISTRY") PERTAINING TO THIS CLAIM.

Authorization & Release

I (name) \_\_\_\_\_ IRREVOCABLY DIRECT AND AUTHORIZE the ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE ("THE MINISTRY") to make payment in respect of my claim for out-of-country/province health services to Industrial Alliance Pacific directly and I hereby release OHIP, upon payment to Industrial Alliance Pacific from any further claim or cause of action in connection therewith.

In giving my authorization I also give my consent to Industrial Alliance Pacific to disclose to the Ministry such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Industrial Alliance Pacific. I understand the purpose for the Ministry's collection and Industrial Alliance Pacific's disclosure of this personal health information. I understand that I can refuse to sign this consent form.

Consent:

- If providing consent for self as the insured person
or
If providing consent on behalf of an insured person who is not capable of consenting to the collection, use and disclosure of personal health information: I (name) \_\_\_\_\_ am the substitute decision maker for (name of Insured Person for whom you are the substitute decision-maker):
\_\_\_\_\_

NOTE: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

I authorize the Ministry to collect the insured person's personal health information, consisting of:

- information relating to the insured person's receipt of health care services outside of Canada, and
information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from Industrial Alliance Pacific and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Industrial Alliance Pacific. I understand the purpose for the Ministry's collection and disclosure of this personal health information. I understand that I can refuse to sign this consent form.

AUTHORIZATION, RELEASE & CONSENT

My Name (Please Print):

Address: Street City Prov. Postal Code

Home Tel: Work Tel:

Date Signed Signature

Witness Name

Address: Street City Prov. Postal Code

Home Tel: Work Tel:

Date Signed Signature of Witness



Claims Department  
 2165 Broadway West, PO Box 5900  
 Vancouver, BC V6B 5H6  
 Telephone: 1-800-266-5667

# Out-Of-Province Hospital/Medical Insurance Claim Form

Please print in ink

|                  |                     |               |
|------------------|---------------------|---------------|
| Member's Surname | Member's Given Name | Policy Number |
|                  |                     |               |

|                |                        |
|----------------|------------------------|
| Patient's Name | Relationship to Member |
|                |                        |

Patient's Address :  
 Street

|      |          |             |              |
|------|----------|-------------|--------------|
| City | Province | Postal Code | Phone Number |
|      |          |             |              |

|  |  |
|--|--|
| Patient's Health Card Number and Verification Code | Patient's Date of Birth<br>( D D / M M / Y Y Y Y ) |
|  |  |

If insured is a student, please provide name of School and/or name of School Board

|            |                  |
|------------|------------------|
| Grade/Year | School Board No. |
|            |                  |

**Out of Province**

|  |  |             |
|--|--|-------------|
| 1. Departure Date<br>( D D / M M / Y Y Y Y ) | Return Date<br>( D D / M M / Y Y Y Y ) | Destination |
|  |  |             |

|                           |                 |
|---------------------------|-----------------|
| 2. Mode of Transportation | Reason for Trip |
|                           |                 |

|                     |        |      |                   |
|---------------------|--------|------|-------------------|
| 3. Family Physician |        |      |                   |
| Name                | Street | City | Prov. Postal Code |
|                     |        |      |                   |

|                              |        |      |                   |
|------------------------------|--------|------|-------------------|
| 4. First Physician Consulted |        |      |                   |
| Name                         | Street | City | Prov. Postal Code |
|                              |        |      |                   |

|   |  |
|---|--|
| 5. Date of initial onset of illness or injury:<br>( D D / M M / Y Y Y Y ) | Date of Previous Occurrence or Treatment:<br>( D D / M M / Y Y Y Y ) |
|   |  |

6. Diagnosis:

7. If hospitalized\*, advise

|   |  |                  |
|---|--|------------------|
| Date of admission:<br>( D D / M M / Y Y Y Y ) | Discharge Date:<br>( D D / M M / Y Y Y Y ) | Name of Hospital |
|   |  |                  |

Address of Hospital:

Street

|      |          |             |              |
|------|----------|-------------|--------------|
| City | Province | Postal Code | Phone Number |
|      |          |             |              |

**\*If available, please enclose a copy of the Hospital Discharge Report.**

