Provincial Health Replacement Insurance
Comprehensive plan
Claims Information Sheet

This document addresses frequently asked questions related to In-Province Hospital Medical Insurance claims

MEDICAL CLAIMS

- The Provincial Health Replacement Insurance claim form must be completed in full in order to process your claim.
- Please be sure that all prescription Drugs, Paramedical Services, x-ray, or Laboratory Fees are reported in **Section A**.
- Please be sure that all HOSPITAL, MEDICAL EXPENSES or PHYSICIAN'S SERVICES are reported in **Section B - *Physician's Account Record*** section on Page 2 which must be completed by the attending physician (MD). Chiropractors, Physiotherapists, Registered Nurses, or any other service providers are **not eligible** to complete the form.

DENTAL INJURY CLAIMS

- The Provincial Health Replacement Insurance claim form must be completed in full in order to process your claim. If claiming for dental injury, please be sure that Page 1 and **Section C - *Dental Injury*** Section on Page 2 of the claim form are completed.
- Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident related dental treatment received.

IMPORTANT

- The Provincial Health Replacement Insurance claim form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company") within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all expenses being claimed.

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 INSURANCE AND FINANCIAL SERVICES INC.
Life and Health Claims Department, Special Markets Solutions
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Tel: 1-800-266-5667
www.solutionsinsurance.com

In providing this claim form for the convenience of the claimant, the Company 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.

Life and Health Claims Dept.
Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6
Tel: 1-800-266-5667

Provincial Health Replacement Insurance - Comprehensive plan

Please print in ink

Group Name

Policy Number

Insured's Last Name

Insured's First Name

Sex

❑ M ❑ F

Insured's Date of Birth

(D D / M M M / Y Y Y Y)

Patient's Last Name

Patient's First Name

Sex

❑ M ❑ F

Patient's Date of Birth

(D D / M M M / Y Y Y Y)

Full Address in Canada:

Street

City

Province

Postal Code

Phone Number

Type of Coverage:

❑ Insured ❑ Spouse ❑ Dependent

A. This section to be completed if claiming for Prescription Drugs, Paramedical Services, X-rays, or Laboratory Fees

Date Service Rendered (D D / M M M / Y Y Y Y)	Nature of Illness or Injury	Claim Description	Amount Charged	Name of Doctor Prescribing Service	Date First Consulted for Condition (D D / M M M / Y Y Y Y)

Cheque should be payable to: ❑ Insured **OR** ❑ Other (indicate below)

Last Name

First Name

Address:

Street

City

Province

Postal Code

Phone Number

Authorization and Declaration

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information which the Company may need in their assessment of this claim.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Date Signed (D D / M M M / Y Y Y Y)

Claimant's Signature

PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS

(B) Your physician MUST complete this section if claiming for any of the following: Hospital, Medical Expenses or Physician Services

PHYSICIAN ACCOUNT RECORD

To avoid delay in payment please ensure service and diagnostic codes are provided.

Diagnosis (describe complications, if any), Procedures - Use exact wording of schedule of fees

Please provide date that the condition(s) were first diagnosed by any physician:

(D D/M M M/Y Y Y Y)

Service Code	Fee Submitted	Number of Services	Service Date (DD/MMM/YYYY)	Diagnostic Code	Service Code	Fee Submitted	Number of Services	Service Date (DD/MMM/YYYY)	Diagnostic Code

Your total charge for these visits at:

Office	Hospital	Home	Total
$	$	$	$

I declare that the above is a correct statement of services personally rendered by me.

Signed on: (D D/M M M/Y Y Y Y) At

Physician's Name:

❑ MD ❑ Certified Specialist

Physician's Address:

Street

City Province Postal Code Phone Number

(C) Dental - If You Sustained Dental Injury as the Result of an Accident and are Claiming Accident Related Dental Expenses, Please Provide the Following:

Date of Accident: (D D/M M M/Y Y Y Y)

Date of Initial Dental Attention: (D D/M M M/Y Y Y Y)

Full details of accident:

What injuries were sustained:

Please attach a Standard Dental Claim Form, available in your dentist's office, fully completed and signed by your dentist for the accident related dental treatment received.