



IMPORTANT

- This form must be completed and signed by the patient or their legal guardian
- **Please read Section B for claim instructions**

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME		PATIENT FIRST NAME(S)			PERSONAL HEALTH NUMBER (PHN)		
BIRTHDATE (DD / MM / YYYY)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HOME PHONE NUMBER		WORK PHONE NUMBER	
MAILING ADDRESS				CITY / TOWN		PROVINCE POSTAL CODE	
RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)				CITY / TOWN		PROVINCE POSTAL CODE	
HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING							
PREVIOUS RESIDENTIAL ADDRESS 1				CITY / TOWN		PROVINCE POSTAL CODE	
PREVIOUS RESIDENTIAL ADDRESS 2				CITY / TOWN		PROVINCE POSTAL CODE	
NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA						EMPLOYER OF <input type="checkbox"/> PATIENT <input type="checkbox"/> HEAD OF FAMILY	
NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)							
REASON FOR ABSENCE FROM BRITISH COLUMBIA						MONTH DAY YEAR	
<input type="checkbox"/> VACATION <input type="checkbox"/> STUDENT						DATE OF DEPARTURE FROM BC	
<input type="checkbox"/> MOVED <input type="checkbox"/> BUSINESS TRIP						DATE OF RETURN TO BC	
<input type="checkbox"/> OBTAIN MEDICAL CARE <input type="checkbox"/> OTHER (SPECIFY):							
DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, NAME OF COMPANY			POLICY NUMBER
ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, attach statement of payment of claims</b>							

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Medical Services Plan to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Medical Services Plan to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the Hospital Insurance Act of British Columbia.

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

<b>If legal guardian, provide name and relationship to patient</b>		
SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information on this form is collected under the authority of the Medicare Protection Act and the Hospital Insurance Act. The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown in Section D of the form. Personal information is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act and may be disclosed only as provided by that Act.

## SECTION B - GENERAL INFORMATION

### CLAIM INSTRUCTIONS

- Attach original receipts and billing invoices to your claim.
- Claims for physician services must be received within 90 days
- Claims for hospital services must be received within 6 months, of the date of discharge
- Receipts and billing invoices not in English or French must include a translation.
- Keep copies of your bills and receipts for your records.

### IF YOU HAVE PRIVATE TRAVEL INSURANCE OR AN EXTENDED HEALTH CARE PLAN, CONTACT YOUR TRAVEL PLAN BEFORE SENDING YOUR CLAIM TO HEALTH INSURANCE BC (HIBC).

#### FOR MORE INFORMATION:

Ministry of Health and HIBC Website: <https://www.health.gov.bc.ca/exforms/msp/occ.html>

Please check your claim form is complete and signed.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow **10-12 weeks** for processing.

#### SEND YOUR CLAIM TO:

HEALTH INSURANCE BC  
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

#### FOR ASSISTANCE, CONTACT:

HEALTH INSURANCE BC  
Phone: 604 683-7151 (Lower Mainland), 1 800 663-7100 (Toll-free BC)

### PROVINCIAL COVERAGE INFORMATION

#### EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited.

Provincial coverage for emergency out-of-country:

- physician services is limited to the B.C. physician fee rates
- dental surgery performed in an acute care hospital (patient safety/medical complexity) is limited to the B.C. oral surgery fee rates
- in-patient hospital services is limited to a daily maximum payment of \$75.00 CAN

Any difference in fees will be the beneficiary's responsibility.

For more information, visit the Ministry of Health website: [www.gov.bc.ca/MSPCoverage-LeavingBC](http://www.gov.bc.ca/MSPCoverage-LeavingBC)

#### ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident leaves Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services **must be requested PRIOR** to leaving BC.

Important coverage information and the requirement for medical documentation is available on the Ministry of Health website: <http://www.health.gov.bc.ca/msp/info/ben/leavingbc.html#outsidecan>

#### PROVINCIAL COVERAGE IS NOT PROVIDED FOR:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - school or university
  - immigration purposes
  - life insurance
  - employment
  - recreational/sporting activities

#### PROVINCIAL COVERAGE IS NOT PROVIDED OUTSIDE B.C. FOR

- ambulance services
- podiatry
- physical therapy
- home care services
- massage therapy
- optometry
- chiropractic
- midwife services
- naturopathy
- prescription drugs
- acupuncture

## SECTION C – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE

DURATION OF ANAESTHESIA

\_\_\_\_\_ HRS \_\_\_\_\_ MIN

OR

FROM \_\_\_\_\_ TO \_\_\_\_\_

LABORATORY TESTS

AMOUNT PAID  
(ENCLOSE PROOF OF PAYMENT)

\$

SPECIFY EACH AREA X-RAYED

AMOUNT PAID  
(ENCLOSE PROOF OF PAYMENT)

\$

### PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

**\*\*AMOUNT PAID – ENCLOSE PROOF OF PAYMENT**

<b>1</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>2</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>3</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>4</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>5</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>6</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$
<b>7</b>	DOCTOR'S NAME AND SPECIALTY				COUNTRY AND CURRENCY			HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO								
	DATE OF VISIT:	MONTH	DAY	YEAR	TYPE OF VISIT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	TIME OF VISIT <input type="checkbox"/> 8 AM - 6 PM <input type="checkbox"/> 6 PM - 11 PM <input type="checkbox"/> 11 PM - 8 AM			AMOUNT PAID** \$

## SECTION D – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- In-patient hospital charges include registered bed patient, dialysis, and surgical day care.
- Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.
- A separate application is required for each admission to hospital.
- If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.

NAME OF HOSPITAL										
MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE										
ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION										
DATE OF ADMISSION:	MONTH	DAY	YEAR	DATE OF DISCHARGE:	MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) \$

### RESIDENCY INFORMATION

A person must be a B.C. resident to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.; and
- must be physically present in B.C. at least six months in a calendar year, or a shorter prescribed period.\*

\* Eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

For more information:

<https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/eligibility-and-enrolment/are-you-eligible>