MEDAVIE BLUE CROSS™

ONTARIO

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX: 506-867-4125

We have been notified that you have incurred medical expenses while traveling outside Ontario. To co-ordinate your benefits between Medavie Blue Cross and OHIP, **we request the following authorization form be completed, signed and returned c/o Travel Claims at the address above.**

Due to time constraints with the provincial health plan, we ask that you please complete this form and return it to our office within thirty (30) days of receipt. Should this form *not* be received in our office in a timely manner, any claims incurred would become the responsibility of you, the member.

ID Number: _____ Policy Number: _____

Departure Date: _____ Return Date: _____

Patient Information:

Name of Patient: _____ Telephone Number _____
First name Family name

Address: _____
No. and Street (Apt.) City Province Postal Code

OHIP Number (Alpha Character) _____ Date of Birth Year _____ Month _____ Day _____

OTHER COVERAGE - TO BE COMPLETED BY MEMBER

Are any travel benefits being claimed available to you or your dependent from any other insurance, WCB, credit card or government plan?
☐ Yes ☐ No **If yes, please provide the following:**

Has the other insurance company been notified? ☐ Yes ☐ No

Name and address of other insurer: _____

Cardholder: _____ ID Number: _____

WCB Claim Number: _____ WCB Address: _____

US Medicare Number (if applicable): _____

SPECIAL AUTHORIZATION AND DIRECTION

1. I authorize Medavie Blue Cross and its signing officers as my attorneys to receive in my name and endorse and negotiate on my behalf, cheques and other forms of payment from my Provincial or Territorial Health Insurance Plan (OHIP) for the reimbursement of claims relating to hospital and medical services incurred during a trip outside my place of residence pursuant to and during the period of my Blue Cross coverage, including any authorized extension of such coverage.
2. I irrevocably direct and authorize OHIP to make payment in respect of all future claims for health services incurred while out of country, to Medavie Blue Cross directly and I hereby release OHIP, upon payment to Medavie Blue Cross, from any claims or causes of action in connection with such payments and I further agree to indemnify OHIP from any and all losses, damages, costs, claims, etc. arising out of or in connection with such payments to Medavie Blue Cross.
3. I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage the Company's business.
4. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.
5. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting to its disclosure. For additional information regarding Blue Cross privacy policies I can contact Blue Cross at 1-800-667-4511 or medaviebc.ca should I have questions as to the collection, use or disclosure of my personal information.
6. I authorize Medavie Blue Cross to request and receive medical information required to assess the eligibility of claims incurred by me during my period of travel as indicated above. This information may be obtained from any health care organization or treating physician providing me with medical services during this period of time.
7. I acknowledge that the information collected and used by OHIP on this form and related to any claims for which I am entitled to payment by OHIP is collected for the purposes of assessing my claim, processing payment therefore and any related purposes in accordance with section 4.1(1) and 4.1(2) of the Health Insurance Act.

I authorize Blue Cross and OHIP to collect, use and disclose my personal information as described above. This authorization shall be valid until such time as all claims submitted by me for the period described above have been assessed for eligibility and paid by OHIP.

Signature _____ **Date** _____

If patient is under the age of 16 years, must be signed by parent or legal guardian

Please return the original of this form along with original receipts and/or invoices. Keep copies for your records.