INTERNATIONAL SHORT TERM HEALTH PLAN
EXPENSE CLAIM FORM

This form is to be completed and submitted if you have paid up front for medical expenses.

INSTRUCTIONS

IMPORTANT

- All claims must be reported to Medavie Blue Cross™ within 90 days of occurrence.
- You are responsible for all fees charged for any supporting documentation.
- Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.

CLAIMS SUBMISSION

- Complete all sections and ensure this form is signed before submitting to Medavie Blue Cross™ with all invoices, physician and medical reports detailing treatment dates, and prescription pharmacy receipts. Keep copies for your records.
- If payment is to be issued to a provider or another entity, please ensure this is accurately detailed in Section E.

SECTION A: CLAIMANT

Claimant's First Name: Claimant's Last Name:

Date of Birth (MM/DD/YYYY): Policy #: Student ID #:

Email: Home Country:

☐ Male ☐ Female Educational Institution:

Policy Start Date (MM/DD/YYYY): Policy End Date (MM/DD/YYYY):

Do you have other insurance?: ☐ Yes ☐ No If "yes", what is the insurance company name?:

Your Policy Number: Your ID Number:

CLAIMANT'S ADDRESS WHILE IN CANADA

Street Address: City/Town:

Province: Postal Code: Telephone: ( )

SECTION B: CLAIM INFORMATION

Description of your sickness or injury (if this space proves insufficient, additional information can be attached):

Date your symptoms first appeared or the injury occurred (MM/DD/YYYY):

Have you ever been treated for this, or a similar or related, condition before?: ☐ Yes ☐ No

Date you first saw a physician for this, or a similar or related, condition (MM/DD/YYYY):

If you answered "yes" above, provide all dates of treatment and list all medications taken before the effective date of the current policy:

Treatment Date (MM/DD/YYYY): Medication:

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Did you obtain the services outside of Nova Scotia?: ☐ Yes ☐ No

If "yes", please indicate the city, province or state, and country:

What date did you depart Nova Scotia? (MM/DD/YYYY):

What date did you return to Nova Scotia? (MM/DD/YYYY):

24/7 EMERGENCY ASSISTANCE:
Medavie Blue Cross™
1-800-563-4444

ASSISTANCE IN COMPLETING THIS FORM:
Student VIP International
admin@internationalhealth.ca
1-888-918-5056 ex. 42

CLAIMS SUBMISSION:
Medavie Blue Cross
Attn: International Student VIP – Montreal Claims Dept
550 Sherbrooke Street West, L-15
Montreal, QC H3A 6T6

admin@internationalhealth.ca
Fax: 1-844-622-6063

SECTION C: EXPENSES CLAIMED

NAME OF PROVIDER	REASON FOR VISITING THE DOCTOR & DIAGNOSIS	DATE OF SERVICE (MM/DD/YY)	AMOUNT BILLED ($)	AMOUNT PAID ($)

SECTION D: AUTHORIZATION & CERTIFICATION

I certify that I have not claimed and will not claim these expenses under any other insurance plan (unless indicated above), and that all information contained herein is correct.

Medavie Blue Cross™, it's agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. The use and disclosure of this information is only for the purposes of administering your policy/ policies of insurance, providing customer service, and in assessing and paying claims. Medavie Blue Cross™ is committed to protecting the privacy, confidentiality, and security of the personal information they collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Medavie Blue Cross' complete privacy policies are available upon request.

I hereby authorize the release of any information or records requested in respect to this claim to the insurer or its agents and certify that the information given is true, correct, and complete to the best of my knowledge.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by my Blue Cross plan may be collected, used, or disclosed to administer and manage the terms of my plan of which I am an eligible member or dependent. For the purposes listed above, limited personal information may be collected from and/or released to a third party. This third party may include another Blue Cross organization, a licensed physician, health care professional or institution, life and health insurer, government and regulatory authorities, a physician in my home country, my educational institution, or any plan under which I am a member, a dependent, or another third party.

CASL AUTHORIZATION: I have read, understand and consent to receive communications from Medavie Blue Cross™ and Student VIP International by e-mail. If you wish to no longer receive communications by e-mail please call 1-833-867-3468.

☐ **I certify that the information provided in connection with this claim is complete, true, and accurate to the best of my knowledge.**

Name of Insured (please print):

If Insured is a minor or unable to sign, print full name of parent/legal guardian/authorized representative:

Signature of Insured/parent/legal guardian/authorized representative: _____

Signature of Policy Holder: _____

SECTION E: ASSIGNMENT OF BENEFITS

This claim is payable to: ☐ Insured at the address in Section A ☐ Parent/Guardian ☐ Hospital/Clinic ☐ Physician ☐ Other

If applicable, I authorize payment of this claim to (print name):

Address, if different from Section A above:

If applicable, full address of payee named above:

Date signed (MM/DD/YYYY):

Please contact the claims department immediately if you have made payment(s) for any services noted in Section C at a later date and need to change the payee in Section E.

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