Provincial Health Alternative Student Insurance Claims Information Sheet

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

MEDICAL CLAIMS

- The Provincial Health Alternative Insurance claim form must be completed in full in order to process your claim.
- Please be sure that all Paramedical Services, x-ray, or Laboratory Fees are reported in **Section A – Paramedical Services**.
- Please ensure that **Section B – Physician Account Record** is completed by the attending physician (MD).
- Please ensure to attach all Original Invoices or Receipts.

DENTAL INJURY OR DENTAL EMERGENCY CLAIMS

- The Provincial Health Alternative Insurance claim form must be completed in full in order to process your claim.
- Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident or emergency related dental treatment received.
- Please ensure that **Section C – Dental** is fully completed by your Dental Provider.

IMPORTANT

- The Provincial Health Alternative Insurance claim form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company") within 90 days of the date of the accident or commencement of sickness, regardless of whether expenses have been incurred. Attach only original receipts for all expenses being claimed.
- If your claim is for emergency medical expenses incurred out of your province of residence, please contact our office for the necessary Claim Forms.

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
400 – 988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Tel: 1-800-549-7227
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.

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Life and Health Claims Dept.
Special Markets Solutions
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6
Tel: 1-800-549-7227

Provincial Health Alternative Student Insurance

Please print in ink

School or College Name

Policy Number

Student's Last Name

Student's First Name

Sex

❑ M ❑ F

Student's Date of Birth

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

Patient's Last Name

Patient's First Name

Sex

❑ M ❑ F

Relationship to Student

❑ Insured ❑ Spouse ❑ Dependent

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

(A) This section to be completed if claiming for Paramedical Services, X-rays, or Laboratory Fees

Are any benefits or services provided under any other group insurance or plan?

Yes ❑ No ❑

Name of Insuring Company

If "Yes", have you claimed these expenses to them? Yes ❑ No ❑

Please enter the total amount claimed for Paramedical Services, X-rays, or Laboratory Fees: $ _____

Should benefits be payable, please select the following:

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)

Signature of Parent, or Legal Guardian or Insured

PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS

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(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 (D D / M M M / Y Y Y Y)	Diagnostic Code	Service Code	Fee Submitted	Number of Services	Service Date (D D / M M M / Y Y Y Y)	Diagnostic Code

Your total charge for these visits at:

Office	Hospital	Home	Total
$	$	$	$

Physician's Name:

❑ MD ❑ Certified Specialist

Physician's Address:

Street

City | Province | Postal Code | Phone Number

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

Physician's Signature _____ (D D / M M M / Y Y Y Y)

(C) Dental - Your Dentist MUST complete this section if you sustained Dental Injury as the result of an Accident or if you received Emergency Dental Treatment.

Reason of Dental Visit

Accident: Yes ❑ No ❑ Emergency Dental Visit: Yes ❑ No ❑ Tooth number: _____

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)

Description of Damage: _____

Were these tooth whole or sound prior to the accident? Yes ❑ No ❑ If "No", please describe: _____

Description of Treatment: _____

Dentist's Name:

Dentist's Address:

Street

City | Province | Postal Code | Phone Number

Dentist's Signature _____ (D D / M M M / Y Y Y Y)

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