



## CLAIM AND AUTHORIZATION FORM

Send the original completed claim form and supporting documents to:

**Canadian Address**

Penfield Care, Inc  
310-260 Hearst Way  
Ottawa, Ontario K2L 3H1

**United States Address**

Penfield Care, Inc  
431 State Street - Suite 1235  
Ogdensburg, NY 13669

PH 800.705.5991  
FAX 613.801.0770

claims@penfieldcare.com  
www.penfieldcare.com

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### PATIENT INFORMATION-MEDICAL

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ (DD/MM/YYYY) Phone # \_\_\_\_\_

Address (Number & Street) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Email \_\_\_\_\_

Relationship to policy holder Same  Spouse  Child

Other (please specify)  \_\_\_\_\_

### POLICY HOLDER INFORMATION (If different from patient)

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (DD/MM/YYYY) Phone # \_\_\_\_\_

Address (Number & Street) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Email \_\_\_\_\_

## CLAIM DETAILS

Trip Departure Date: \_\_\_\_\_ Trip Return Date: \_\_\_\_\_

The date you sought medical attention: \_\_\_\_\_

The reason for seeking medical attention (diagnosis): \_\_\_\_\_

If you incurred "out of pocket" expenses and your claim is payable should the cheque be made to patient?

- Yes  Claim will be paid out to patient  
 No  Please provide name and address for cheque recipient:

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## MEDICAL EXPENSES LIST

Eligible expenses paid (i.e. prescriptions, Dr. visits, meals, ambulance, etc.)	Date Incurred	Amount	Currency	Original Receipt Enclosed Y/N

**\* If your expenses are in more than one currency, please total each separately & Please attach another sheet if your expenses exceed the space provided**

## REIMBURSEMENT PREFERENCE

Cheque  Electronic funds transfer

Associated email for electronic funds transfer \_\_\_\_\_

Preferred currency CDN  USD

## CANADIAN FAMILY DOCTOR AND/OR SPECIALIST INFORMATION

Your medical history may be required to fully review your claim. Please provide your Canadian physician(s) information below:

PHYSICIAN	Telephone
Family Physician	
Walk-In Clinic (if available)	
Canadian Specialist	
Specialist (other)	

## OTHER INSURANCE INFORMATION

### 1. Please enter your Provincial Health Insurance Plan number (including version code):

\_\_\_\_\_

(For Ontario, depending on date OHIP card was issued/renewed, Version Code may be 0/1/2 letters)

### 2. Are you or your spouse entitled to benefit under any other plan for the medical expenses being claimed?

YES  NO

If YES, please provide details below: If NO, leave blank and complete the next section:

INSURANCE	YOU	SPOUSE
Insurance Company		
Plan Number		
Plan Member ID Number		

If spouse plan, please provide spouse's name \_\_\_\_\_

Date of birth \_\_\_\_\_ (DD/MM/YYYY)

### 3. Do you have a credit card with travel insurance coverage? YES NO

If YES, please provide detail below: To help you receive all additional payments you are entitled to, we will coordinate with any other potential insurers on your behalf. We will determine if the card provides coverage for your incident.

CREDIT CARD DETAILS	
Name on Card	
Card Type	
Card Number	
Expiry Date	

### 4. Was your Medi-Quote travel insurance purchased as a top up? YES NO

If you answered yes, please provide the following details

INSURANCE POLICY TO WHICH 'TOP UP' COVERAGE WAS PURCHASED	
Company or Credit Card Name	
Policy or Credit Card Number	
Effective Dates	(DD/MM/YYYY)

## CONSENT/AUTHORIZATION & RELEASE SPECIFICATIONS

This section provides Penfield Care Inc. authorization to obtain, recover and forward information, payments and/or obtain recovery from your Provincial health insurance plan

**1. Direction and release** I, \_\_\_\_\_ personally or as the authorized substitute/proxy for (the insured patient) \_\_\_\_\_ Irrevocably direct and authorize the Provincial Ministry of health and long-term care (The Ministry) to make payment in respect of my claim, or if applicable the insured patient's claim, for out of country health services directly to Penfield Care Inc and hereby release the ministry, upon payment to Penfield Care Inc., from any further claim or cause of action in connection therewith. Note: An authorized substitute/proxy is a person authorized under PHIPA to consent on behalf of an individual to disclose personal health information about the individual.

**2. Consent I authorize the ministry to collect my/the insured patient's personal health information, consisting of:**

- Information relating to my/the insured patient's receipt of health care services outside Canada and
- Information relevant to the reimbursement of those services under the health insurance Act and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my/the insured patient's request for payment under the health insurance act. Including the details of any duplicate payment previously made to me/the insured patient, to Penfield Care Inc. I understand the purpose for the Ministry's collection and disclosure of their personal health information.

You have the right to refuse to sign this consent form, however, Penfield Care Inc and the Ministry will be unable to process your/the insured patient's claim if this form is unsigned.

**3. Authorization My/Insured patient's name** \_\_\_\_\_

Address \_\_\_\_\_

Telephone number \_\_\_\_\_ Other phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone number \_\_\_\_\_ Other phone \_\_\_\_\_

Witness signature \_\_\_\_\_

Date \_\_\_\_\_

**GENERAL AUTHORIZATION TO RELEASE**

- 1. I assign to Penfield Care Inc. any amount obtainable from other sources for covered losses under this policy. I also direct this source to forward payment to Penfield Care Inc. for my claim submitted by Penfield Care Inc. with regards to these losses and to exchange information that facilitates this process.
- 2. I authorize any hospital physician or medical facility to send my medical information to Penfield Care Inc. authorized representative of the insured. I further consent to the disclosure of this information by Penfield Care Inc to other sources as may be required to obtain benefit from other sources.
- 3. I warrant that neither I or any insured person have any additional coverage through any other insurer (other than that listed above)
- 4. I understand that my insurance shall be void, if whether before or after the loss, any person had concocted or misrepresented any fact or circumstance concerning the claim

Patient or authorized person's signature \_\_\_\_\_

Date \_\_\_\_\_