Government of Alberta

PO Box 1360 Stn Main
Edmonton, AB T5J 2N3

Out-of-Country Health Services Claim Form

1. Complete this form to assist in settling your claims promptly.
2. Please attach clear copies of itemized statements of practitioner and hospital charges on an official statement or letterhead. We recommend you keep the originals for your own records.
3. All bills and receipts in a foreign language must be translated into English. A copy of both the foreign language and the English version must accompany your claim.
4. Claims must be received by Alberta Health and Wellness within 365 days from the date of service.
5. Please allow up to 12 weeks for processing.

Section A – Patient information (please print clearly)

Personal Health Number _____ – _____

Date of Birth YYYY MM DD _____

Last name | First name | Middle initial

If someone other than the person responsible for the Alberta Health Care Insurance Plan account paid for these services and the benefits paid by Alberta Health and Wellness should be paid to them, please complete the following section and provide proof of payment.

Payer's name

Personal Health Number *(if applicable)* _____ – _____

Address *(if different from account holder)*

Section B – Claim summary

Type of service(s) and brief description of each service received:

Practitioner services

Service performed

- ☐ Visit(s)
- ☐ Specialist consultation(s) resulting from a referral
- ☐ Other (describe) _____
- ☐ Surgical procedure(s)
- ☐ X-rays
- ☐ Laboratory tests

Date of service

YYYY MM DD _____

Note: Physician services provided in hospitals must be submitted separate from the hospital bill. If you have had major surgery and received a copy of the surgical/operative report, please attach a copy.

Total charge(s):

Country where services were provided:

Hospital services

Hospital name/address

If admitted to hospital, provide the following:

Admission date YYYY MM DD _____

Discharge date YYYY MM DD _____

If not admitted, what hospital service(s) did you receive?

Emergency visit only? ☐ Yes
Physical therapy? ☐ Yes
Outpatient? ☐ Yes
Day surgery? ☐ Yes
Other (describe)_____
Date of service(s) YYYY MM DD _____

Total charge(s):

Country where services were provided:

Section C – Declaration

I certify that the information provided on this form is true and correct to the best of my knowledge.

Signature _____ Date _____

General information

For further information regarding coverage, obtain the AHC0012 *Travel Health Insurance Matters* brochure through our website at www.health.alberta.ca or by contacting us at 780-422-1954 Fax: 780-422-1958.

Information collected is used to enroll you for programs or benefits funded by Alberta Health and Wellness. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act.* The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act.* If you have any questions about the collection or use of this information, please contact us at the above address or telephone number.