TO SUBMIT A CLAIM

HERE ARE THE STEPS TO SUBMIT A CLAIM

Step 1 . . . . . Gather all your original detailed receipts.

Step 2 . . . . . Complete and sign the *Claim Form*.

Step 3 . . . . . Complete and sign your Provincial Health Insurance Plan form.

CHECKLIST

Have you:

- ☐ Completed and signed the *Claim Form*?
  All incomplete forms will be returned and will delay your claim assessment.
- ☐ Attached all original receipts?
  Photocopies will not be accepted.
- ☐ Completed and signed your Provincial Health Insurance Plan form?
  All incomplete forms will be returned and will delay your claim assessment.
- ☐ Made photocopies for your records?

IMPORTANT NOTES

- All aforementioned documents must be received within 90 days of your return to your province of residence.
- Cash register coupons (stubs) will not be accepted for reimbursement.
- Any fees for the completion of medical certificates or claim forms are your responsibility.

SEND ALL YOUR DOCUMENTS TO:

LS-Travel
Att: Claims department
247 Thibeau Boulevard
Trois-Rivières (Quebec) G8T 6X9

To verify your claim status:

Toll free: 1-877-344-8398
Email: claimsfollowup@tourmed.ca

WWW.TOURMED.CA
Telephone: 1 877 344-8398
Fax : 1 819 377-6069

247 Thibeau Blvd.
Trois-Rivières (Québec) G8T 6X9

COLLECT COLLECT Total

CLAIM FORM

Insured by LS insurance company Travel

Group Out-of-Province Travel Medical Emergency Insurance

This claim form is mandatory whether you have incurred out of pocket expenses or not.

This claim form must be completed, signed and returned to the Insurer as soon as possible but no later than 90 days after your return in your province of residence.

If you need assistance in completing this claim form, our Claims team will answer your questions from Monday to Friday, 8:30AM to 5:00PM EST. Call toll free 1-877-344-8398 or collect 1-819-377-1777.

PLEASE SUBMIT THE APPLICABLE SUBSTANTIATING DOCUMENTATION

- Original detailed invoices or receipts. Please note that photocopies or cash/cashier receipts are not accepted.
- **A proof*** of your **Departure date** from your province of residence is mandatory.
  (* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

PARTICIPANT'S STATEMENT

Name of the Insured and address where to send the refund. Desired currency: CAD ☐ USD ☐

First name ____ Last name ____ Contract Number ____

No. ____ Street ____ apt. # ____ City ____ Province ____ Postal Code ____

Government Health Insurance Number ____ Telephone: (____) ____ Date of birth: ____ / ____ / ____ (dd / mm / yy)

Email Address: ____

Name of the employer: ____

Are you covered by any other travel insurance (private, group, Medicare, credit card)? YES ☐ NO ☐

Company : ____ Policy Number : ____ Telephone : (____) ____

DEPENDANTS - to be completed if the claim is for a Dependant

First Name ____ Last Name ____

Date of Birth: ____ / ____ / ____ (dd / mm / yy) Relationship with Participant: ____

Signature of the Dependant (if has reached age of majority) ____

If the claim is for a Dependant child:

Is he/she married? YES ☐ NO ☐

Does he/she usually live with the Participant? YES ☐ NO ☐

Is he/she a student in a Cegep (college) or university? YES ☐ NO ☐

If yes, name and address of the educational institution: ____

CLAIM EXPENSES

Provide brief description of the expenses and indicate amounts incurred. (If you need more space, please attach a separate sheet).

Name of medical services provider (or any type of services incurred)	Date of service received (dd/mm/yy)	Amount billed	Amount paid by you	Currency
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

CLAIM FOR MEDICAL EXPENSES (PLEASE ANSWER ALL QUESTIONS)

a) Please check the appropriate box: Sickness ☐ Accident ☐ Other ☐ Please specify: ____________________

b) Treatment received in: Office/clinic ☐ Emergency Room of a hospital ☐ Hospital ☐

c) Have the expenses been incurred during a business trip? YES ☐ NO ☐

d) Please provide dates and brief details about this claim.

____

____

____

____

e) In the past, have you ever been treated for those symptoms or illnesses? YES ☐ NO ☐
If YES, please provide the dates and places of consultation.

____

____

f) Please provide name and contact information of your family doctor in Canada.
☐ I don't have a family doctor

Name: ____________________ Telephone: ____________________

Address: ____________________

CERTIFICATION AND AUTHORIZATION

I hereby assign to LS-Travel Insurance Company (the Insurer) any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to the Insurer for my claims submitted by the Insurer with regard to these losses and authorize all parties above to exchange and share information to facilitate the claims process.

I hereby authorize any physician, hospital, other health care practitioners, medical care facilities, insurance carriers, any other person who has attended or examined me and any other source involved in this claim to provide the Insurer any medical and other information needed to process the claim. I also consent that such information be shared with other sources for the Insurer to be able to coordinate the payment of benefits when applicable.

I certify that I have no other insurance coverage than the ones mentioned in this claim form.

I understand that the making of false or fraudulent statement in connection with a claim for benefits will render the insurance policy null and void.

I certify that the statements given in the making of this claim are complete, true and correct to the best of my knowledge.

A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and valid as the original.

Signature of the claimant spouse (if applicable): ____________________ Date: ____________________

Signature of the Participant: ____________________ Date: ____________________

Application for Reimbursement - Medicare
Demande de remboursement - Assurance-maladie

Medicare New Brunswick /
Assurance-maladie du Nouveau-Brunswick
P.O. Box / C.P. 5100, Fredericton, NB E3B 5G8
TeleServices toll free / Numéro sans frais de Téléservices : 1-888-762-8600

Patient Name / Nom du patient	N.B. Medicare # / N° d'Assurance-maladie du N.-B.	Telephone N°/ N° de téléphone (H/D) (W/T)	Date of Birth/ Date de naissance D/J M Y/A
Beneficiary (i.e. parent, spouse, guardian)/ Bénéficiaire (p.ex. : parent, conjoint, tuteur)	Date of service/ Date du service D/J M Y/A	Location of service/ Lieu du service	☐ Inpatient/ Hospitalisation ☐ Office/Bureau ☐ Outpatient Department Services ambulatoires ☐ Other/Autre ______
Address / Adresse	Name and address of service provider / medical practitioner if applicable/ Nom et adresse du dispensateur de service / médecin s'il y a lieu	Diagnosis (Reason for visit) Le diagnostic (raison de la visite)	

Please note: Original signed invoices or receipts (no faxes, photocopies or carbon copies) must be submitted.

In the case of a claim for reimbursement for services rendered inside the province, no payment shall be made for entitled services unless the account or claim for reimbursement is received by Medicare within six (6) months after the date upon which the entitled services were rendered.

In the case of entitled services rendered outside the province, no payment shall be made for entitled services unless the account or claim for reimbursement is received by Medicare within twelve (12) months after the date upon which the entitled services were rendered.

Veuillez noter : Vous devez soumettre les factures ou reçu originaux signés (les télécopies, photocopies ou les copies carbonées ne sont pas acceptables).

Dans le cas d'une demande de remboursement pour des services rendus dans la province, nul paiement ne peut être effectué pour des services assurés à moins que la facture ou la demande de remboursement n'ait été reçu par l'assurance-maladie dans les six (6) mois qui suivent la date de prestation des services.

Dans le cas de services assurés rendus à l'extérieur de la province, nul paiement ne peut être effectué pour des services assurés à moins que la facture ou la demande de remboursement n'ait été reçue par l'assurance-maladie dans les douze (12) mois qui suivent la date de prestation des services.

I hereby apply for payment in respect of the cost of medical and/or hospital services on behalf of myself or the above named patient and certify that the information which I have given is true and correct.

Je demande par les présentes le paiement des services médicaux et/ou hospitaliers reçus par moi-même ou par le patient précité. Je certifie que les renseignements que j'ai donnés sont véridiques et exacts.

Signature ____________________ Date ____________________

The Department of Health is committed to safeguarding your privacy. For more information on our privacy practices and about your rights regarding this issue, go to www.gnb.ca (key word – Privacy Notice).

Le ministère de la Santé est résolu à protéger votre vie privée. Pour plus de renseignements en ce qui a trait à nos pratiques en matière de protection de renseignements personnels, ainsi que de vos droits à ce sujet, consultez le www.gnb.ca (mot clé - Avis sur la protection de la vie privée).

SEND TO:

LS-TRAVEL
247, Thibeau Blvd
Trois-Rivières (Quebec)
G8T 6X9

POWER OF ATTORNEY

I, the undersigned ______________________________
(BLOCK LETTERS)

Empower LS-Travel:

1. To submit to the New Brunswick Medicare, in accordance with the laws and regulations applied by the New Brunswick Medicare, my claims for the insured medical and hospital services which I, my spouse or my children received (family insurance)

in ______________________________
LOCATION

during our stay from ____________________ to ____________________
DATE (YYYY-MM-DD) DATE (YYYY-MM-DD)

2. To transmit to and receive from the New Brunswick Medicare all information and documents required for the assessment and payment of the said claims.

3. To receive from the New Brunswick Medicare all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the New Brunswick Medicare to accept the claims submitted, to act in accordance with this Power of Attorney as specified and to transmit to LS-Travel any information regarding the beneficiary status of myself, my spouse or my children.

____________________ ____________________
SIGNATURE HEALTH INSURANCE NUMBER