



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

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

- d) 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.

2. CLAIM FOR EMERGENCY ROUND TRIP EXPENSES (Section to be filled out only if applicable.)

In all cases, please submit original receipts for air transportation including copy of boarding pass.

- Claim for: **Death** (please submit death certificate or medical report indicating cause of death – Quebec residents: SP3 form is required)
- Hospitalization** (please submit medical certificate indicating diagnosis, admission and discharge dates)
- Disaster** at your principal residence/place of business (please submit substantiating documentation such as police report/private insurance confirmation)

Amount claimed for air transportation: \$ _____

Name of the immediate family member

Date of birth

Relationship to you

Complete address of that person

Hospital admission date

Hospital discharge date

Reason of admission

Date of death

Cause of death

Place of death

In the 6 months prior to your departure date, was the person:

Hospitalized? YES NO If YES, please indicate dates and name of hospital: _____

Suffering from a terminal illness? YES NO

Residing in a long term care facility (CHSLD)/assisted living facility? YES NO

If YES, please indicate name and complete address of that facility: _____

CERTIFICATION AND AUTHORIZATION

I hereby assign to Tour+Med - 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.

Insured's signature: _____

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 <input type="checkbox"/> Inpatient/ Hospitalisation <input type="checkbox"/> Office/Bureau	<input type="checkbox"/> Outpatient Department Services ambulatoires <input type="checkbox"/> 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.

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

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.

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.

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.

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