Let's get started! We're looking forward to helping you with your claim.

Below is the list of required documents and additional information to finalize your claim. Be sure to review each item carefully and complete it as accurately as possible.

It's best to submit your claim forms to us within 60 days from the date the claim was opened—the sooner we receive your completed claim forms, the faster we can start processing your claim.

Here's what we'll need:

- **Excess Hospital/Medical Claim Form**
  - Complete both sides.
  - Sign the bottom of Section 3 to guarantee you have disclosed all additional coverage. Please note: if information is incomplete or inaccurate, we will not be able to process your claim.
  - If you list additional coverage in Section 3, be sure to also sign Section 4.
  - If someone is signing on your behalf, be sure to include a copy of the Power of Attorney to show that they are legally authorized to do so.

- **Schedule A**
  - Complete and sign Schedule A, required for Health Insurance BC.
  - If you make any changes, be sure to initial them.
  - If you are *only* claiming any of the following, this form is not required:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor
    - Prescription glasses replacement
    - Additional air travel related benefits
    - Medical expenses incurred within Canada (other than in Quebec)

(Not all policies cover the above benefits—refer to your policy wording to check your coverage.)

- **All original, itemized bills and receipts**

- **All original prescription drug receipts**
  - Be sure they are the official tax receipts and not credit card or till receipts.

- **Out-of-Country Claim Form** (If hospitalized overnight, this form is required by Health Insurance BC)
  - Complete and sign Section A only, including the Release of Information at the bottom of the section.
  - If the claim is due to an injury or a motor vehicle accident, complete the applicable portions of Section C.
  - If you were not hospitalized overnight, this form is not required.

- **Proof of payment**
  - If you have already paid the medical provider or facility directly, provide proof of the amount paid so we can process your reimbursement.
  - This could be a receipt marked “paid” from the provider, a credit card statement, or a copy of a cancelled cheque.
  - If you paid by credit card, you may want to include a copy of the credit card statement showing the exchange rate and amount charged in Canadian dollars.

- **Written description (if your claim is related to an illness)**
  - Describe the diagnosis, symptoms, or the nature of the illness you are claiming for.

- **Written description (if your claim is related to an injury)**
  - Describe the injury and tell us how it happened.
  - Be sure to include the date and time of the incident as well as the name, phone number and email address (if possible) of the person or company you feel is responsible.

(If you need more space than what is provided on the claim form, feel free to write the above information on a separate piece of paper—any format is fine.)

In the unfortunate event that you are filing a claim for someone who has passed away, please also submit:

- A copy of the Insured’s Death Certificate.

- A copy of the section of the Will indicating who is legally authorized to act on behalf of the Estate.

- If these expenses were incurred while the Insured was travelling, the original receipts for cremation or for homeward carriage for burial.

If you have any questions, feel free to call us toll free at 1-800-663-0399 or collect at 604-278-4108. You can also email us at claims@tugo.com.

We look forward to completing your claim as quickly as possible.

Take care,

Claims at TuGo

Excess Hospital-Medical Claim

Claims at TuGo, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 **Fax:** 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

Claim No.

For office use only

(Please print clearly. This form will be returned if not completed in full.)

Important Reminders:

- Complete all sections of the claim form(s) in full (front and back), signing where indicated.
- Include original, itemized bills, indicating dates and costs of all services provided.
- Keep copies of all bills for your records.
- By submitting this claim form, you warrant that all information provided is true, correct and complete.
- Your provincial health plan is your primary coverage. Most provincial plans have a 90-day deadline for claiming; if you fail to meet the submission deadline for your provincial plan, you will be responsible for the amount that your provincial plan would have paid.

1. GENERAL INFORMATION

Name of the Insured claiming FIRST NAME LAST NAME ○ M ○ F

Policy number _____ Date of birth MM | DD | YYYY

Address _____

City _____ Prov. _____ Postal code _____

Telephone Home ( ) _____ Office ( ) _____

Email _____ Fax ( ) _____

Name of provincial health care plan and Personal Health Number _____

Name, address and telephone number of your usual Canadian physician _____

State the names of any medications you were taking prior to departure _____

Departure date from home province MM | DD | YYYY Return date to home province MM | DD | YYYY

Country where claim occured _____ Currency paid _____

Date Sickness or Injury occurred MM | DD | YYYY

Nature and description of Sickness or Injury claimed _____

2. MEDICAL AUTHORITY

Authorization to physicians, hospitals, other medical providers & other insurers

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to **Claims at** TuGo all information and documentation in their possession that **Claims at** TuGo requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records") and other applicable insurance policy information.
2. I authorize **Claims at** TuGo to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records and other insurance policy information is to enable **Claims at** TuGo and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to **Claims at** TuGo such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from **Claims at** TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME

Print name (and relationship if not claimant)

X _____ MM | DD | YYYY

Signature (Claimant or authorized representative) **Date**

PLEASE COMPLETE AND SIGN REVERSE SIDE

3. OTHER INSURANCE (If claimant is a dependent, provide requested information for parents or guardians.)

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan?

○ Yes ○ No If "Yes", please provide details below:

	Name of Insurance Co.	Telephone#	Group Policy#	Member ID#	Lifetime limit
Your employer/retirement plan					$
Spouse's employer/retirement plan					$

Spouse's name FIRST NAME LAST NAME Spouse's date of birth MM | DD | YYYY

Do you have benefits available through any other travel insurance company or travel supplier? ○ Yes ○ No If "Yes", please provide:

Name of other provider _____ Policy # _____

Address of other provider _____

Did you use a credit card for any of your travel arrangements? (many credit cards offer travel benefits)

○ Yes ○ No If "Yes", please provide:

Name of issuing financial institution _____

Card number _____

FIRST NAME LAST NAME
Name of cardholder (please print)

X _____
Cardholder signature (if different from insured)

MM | DD | YYYY
Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

X _____
Signature (claimant or authorized representative)

FIRST NAME LAST NAME
(Print name)

MM | DD | YYYY
Date

4. CLAIMANT'S ASSIGNMENT OF PAYMENT

I assign to **Claims at** TuGo any benefits obtainable from other sources for covered losses. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to **Claims at** TuGo.

A copy of this authorization received from **Claims at** TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME
Print name (and relationship if not claimant)

X _____
Signature (claimant or authorized representative)

MM | DD | YYYY
Date

X _____
Signature of primary policy holder of other insurance in Section 3 above (if applicable)

MM | DD | YYYY
Date

BC Residents Only

For faster claim service, please complete and SIGN this form and send it with the completed Claim Form and your original bills/receipts to:

Claims at TuGo, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 **Fax:** 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

Schedule A

ASSIGNMENT OF PAYMENT

Personal Health (CareCard) Number of Patient: _____

BETWEEN: _____
Assignor (Adult Patient or Parent/Guardian of Patient)

AND: **Claims at** TuGo
10th Floor - 6081 No. 3 Road
Richmond, BC V6Y 2B2

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter referred to as the Minister.

WHEREAS the Assignor is a person eligible for insured services and/or benefits under the Province of *British Columbia's Medicare Protection Act and/or Hospital Insurance Act*, and as such may receive payment for certain of those services or benefits from the Minister.

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective dates (policy effective dates): from: MM | DD | YYYY to: MM | DD | YYYY

X _____
Signature of Assignor (Patient or Parent/Guardian of Patient)

MM | DD | YYYY _____
Date Signed

Please initial any corrections

BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY CLAIM
(to be filled out by the beneficiary)

Return to: Medical Services Plan, Out-of-Country Claims
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

IMPORTANT

- **Please read the instructions in Section D before completing this form**
- **Attach all original receipts or bills to this form – include itemized statement (receipts not in English must be translated before being submitted)**
- **Claims must be received within 90 days of the date of service**
- **If you leave Canada specifically to obtain medical care, you must receive prior approval for payment of insured services – see Section D, Elective Services on page 4**
- **This form must be completed and signed by the patient or their legal guardian**
- **Retain copies of bills or receipts for your records**

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME(S)	PERSONAL HEALTH NUMBER (PHN)

BIRTHDATE (DD / MM / YYYY)	GENDER	HOME PHONE NUMBER	WORK PHONE NUMBER
	☐ MALE ☐ FEMALE		

MAILING ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE

RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / TOWN	PROVINCE	POSTAL CODE

HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC?

☐ YES ☐ NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING

PREVIOUS RESIDENTIAL ADDRESS 1	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

PREVIOUS RESIDENTIAL ADDRESS 2	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA	EMPLOYER OF
	☐ PATIENT ☐ HEAD OF FAMILY

NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)

REASON FOR ABSENCE FROM BRITISH COLUMBIA

☐ VACATION ☐ STUDENT
☐ MOVED ☐ BUSINESS TRIP
☐ OBTAIN MEDICAL CARE ☐ OTHER (SPECIFY):

	MONTH	DAY	YEAR
DATE OF DEPARTURE FROM BC			
DATE OF RETURN TO BC			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE?	IF YES, NAME OF COMPANY	POLICY NUMBER
☐ YES ☐ NO		

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY?

☐ YES ☐ NO ***If yes, attach statement of payment of claims***

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Out-of-Country Claims, Medical Services Plan, to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the *Hospital Insurance Act* of British Columbia (for in-patient hospital charges).

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

	If legal guardian, provide name and relationship to patient	
SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information on this form is collected under the authority of the *Medicare Protection Act* and the *Hospital Insurance Act.* The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown in Section D of the form. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

SECTION B – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	DURATION OF ANAESTHESIA _____ HRS _____ MIN OR FROM _____ TO _____
LABORATORY TESTS	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $
SPECIFY EACH AREA X-RAYED	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

****AMOUNT PAID – ENCLOSE PROOF OF PAYMENT***

1	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
2	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
3	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
4	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
5	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
6	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
7	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH / DAY / YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $

SECTION C – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- **In-patient hospital charges include registered bed patient, dialysis, and surgical day care.**
- **Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.**
- **A separate application is required for each admission to hospital.**
- **If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.**

NAME OF HOSPITAL

MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE

ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION

DATE OF ADMISSION: MONTH	DAY	YEAR	DATE OF DISCHARGE: MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT? ☐ YES ☐ NO	AMOUNT PAID **(ENCLOSE PROOF OF PAYMENT)** $

ACCIDENTAL INJURY (If hospitalization was the result of an accidental injury, complete this section)

DATE OF ACCIDENT: MONTH	DAY	YEAR	ACCIDENT LOCATION

TYPE OF ACCIDENT

- ☐ AUTOMOBILE - (YOU WERE):
  - ☐ DRIVER IN TWO/MULTI-CAR COLLISION
  - ☐ PASSENGER IN TWO/MULTI-CAR COLLISION
  - ☐ PEDESTRIAN STRUCK BY AUTOMOBILE
  - ☐ CYCLIST STRUCK BY AUTOMOBILE
  - ☐ DRIVER IN AUTOMOBILE SHOW
  - ☐ PASSENGER IN AUTOMOBILE SHOW
- ☐ OTHER TYPE OF ACCIDENT (SPECIFY):

DESCRIBE HOW THE ACCIDENT TOOK PLACE

WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

NAMES, ADDRESSES AND INSURANCE INFORMATION (IF KNOWN) OF OTHER DRIVERS/PERSONS INVOLVED IN ACCIDENT

1

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

2

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

3

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

SECTION D - GENERAL INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited. For information about coverage, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html

Medical Services Plan (MSP) coverage for emergency out-of-country, physician services is limited to the B.C. physician fee rates.

Provincial coverage for emergency out-of-country, in-patient hospital services is limited to $75.00 CDN per day.

Any difference in fees will be the beneficiary's responsibility.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow 12-16 weeks for processing.

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident plans to leave Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services must be approved by MSP **PRIOR** to leaving BC. Important coverage information and the requirement for medical documentation is detailed on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

MSP DOES NOT PROVIDE COVERAGE FOR THE FOLLOWING:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - employment
  - life insurance
  - immigration purposes
  - school or university
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED *OUTSIDE B.C.* FOR THE FOLLOWING:

- ambulance services
- prescription drugs
- midwife services
- massage therapy
- physical therapy
- naturopathy
- chiropractic
- podiatry
- acupuncture
- optometry
- home care services

DENTAL AND ORAL SURGICAL PROCEDURES

MSP coverage for Dental and Oral surgical procedures is limited to surgery that must be performed in an acute care hospital for patient safety and the medical complexity of the surgery. For detailed coverage information, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/benefits.html#benefits

For more information on submitting an Out-of-Country Claim, visit the Ministry of Health website:
https://www.health.gov.bc.ca/exforms/msp/occ.html

IF YOU REQUIRE FURTHER INFORMATION, CONTACT HEALTH INSURANCE BC AT:

Health Insurance BC
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7
Web: www.hibc.gov.bc.ca

Phone: 604 683-7151 (Lower Mainland)
1 800 663-7100 Toll-free (Rest of BC)
Fax: 250 405-3588

BEFORE MAILING: *Please ensure you have completed your claim form*
Attach all receipts or bills to this form – include itemized statements
Ensure that you have signed all appropriate areas