

CLAIM FORM

iMED HEALTH INSURANCE FOR NEW UBC INTERNATIONAL STUDENTS



MSH INTERNATIONAL administers claims made to iMED Health Insurance for New UBC International Students. Complete this claim form to be reimbursed for eligible medical expenses that you have paid out of pocket, OR for direct payment of eligible medical bills to the medical provider.

In Section 5, please indicate to whom this claim should be paid. If payment must be made to multiple parties, please complete a separate claim form for each.

Please note that both pages of this form must be completed in full, with all related bills, receipts, and medical records attached, for your claim to be processed by MSH International.

IMPORTANT: Please submit claims promptly. For additional details on claim submission deadlines, please refer to your policy wording.

For questions about your coverage or help with filing a claim, contact MSH International. You will need to provide the policy number on your insurance ID card, **your UBC student number, and present your name as it appears on your iMED Card.**

INSURED & PATIENT INFORMATION

PRIMARY INSURED INFORMATION (THE INTERNATIONAL STUDENT/INTERN)

UBC - iMed			
Name of School		Policy Number on Insurance ID Card (and Certificate Number, if known)	
Last Name		First Name	
Gender	Date of Birth (MM/DD/YYYY)	Home Country	
Phone Number		Email Address	

Do you have other insurance coverage? Yes No Are you submitting a claim with this other insurer? Yes No

IF YES, please provide the other insurer's name and telephone number, as well as your policy number with them:

Please create a confidential MSH International online account where I can look up my claims history and status. Yes No
If you select yes, the username and password for your confidential online MSH Member Site account will be sent to the email address provided above.

PATIENT INFORMATION (THE INSURED PERSON WHO RECEIVED THE MEDICAL SERVICES)

Last Name		First Name	
Gender	Date of Birth (MM/DD/YYYY)	Insurance Effective Date (MM/DD/YYYY)	Insurance Expiry Date (MM/DD/YYYY)

Was this medical care received following an accident? Yes No

IF YES, please provide details, including the date and location of the accident:

MEDICAL SERVICES

1.			
	Medical Provider Name	Date of Service (MM/DD/YYYY)	Cost

Describe your symptoms / reason for seeking medical attention, the condition / diagnosis given, and the services received:

Have you consulted a physician, or been treated, for this condition before? Yes No

IF YES, please provide details, including how long you have had this condition:

2.			
	Medical Provider Name	Date of Service (MM/DD/YYYY)	Cost

Describe your symptoms / reason for seeking medical attention, the condition / diagnosis given, and the services received:

Have you consulted a physician, or been treated, for this condition before? Yes No

IF YES, please provide details, including how long you have had this condition:

3.			
	Medical Provider Name	Date of Service (MM/DD/YYYY)	Cost

Describe your symptoms / reason for seeking medical attention, the condition / diagnosis given, and the services received:

Have you consulted a physician, or been treated, for this condition before? Yes No

IF YES, please provide details, including how long you have had this condition:

FOR MEDICAL PROVIDERS ONLY

Please check all that apply:

Prescription given
 X-ray ordered
 Lab work ordered
 Other: _____

Physician Name	Date (MM/DD/YYYY)

Physician Signature

NOTE: Medical providers may bill eligible medical expenses directly to MSH International.

CLAIM PAYMENT INFORMATION

THIS CLAIM IS PAYABLE TO:

Last Name	First Name		
	Street		
	State/Province	Country	ZIP / Postal Code
Phone Number	Email Address		

SELECT A PAYMENT METHOD

Cheque payment by mail*
 Wire transfer**

* Cheque payments are in CAD. Requests for payment in other currency are approved on a case-by-case basis by MSH International.
 **For wire transfer payment, you must attach a VOID cheque and provide banking details below.

BANKING DETAILS

Beneficiary Bank Name	Bank Identification Number		Beneficiary Account Number
Bank Address		SWIFT	
Beneficiary Name	ABA Code (Accounts in the USA)		SWIFT Code (All Other Accounts)
Beneficiary Address			

DECLARATION AND AUTHORIZATION

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I authorize any hospital, physician, other medical provider or insurer to provide by any means (including fax, mail or email) my complete medical records to MSH International for the purpose of administering claims. I authorize payment to be made to the party named above for ALL expenses claimed on this form.

I certify that the above information is true.

Insured Signature	Date (MM/DD/YYYY)

Claims under \$10,000 may be submitted by fax or email. You must keep the original record of your claim for 24 months in case of a claim audit. To process a claim over \$10,000, you must submit the original claim documents by mail.

SUBMIT ALL CLAIMS TO:	MSH INTERNATIONAL Suite 2900, 605 – 5th Street S.W. Calgary AB Canada T2P 3H5 FAX +1 (403) 265-9425 EMAIL claimsamerica@msh-intl.com TOLL-FREE PHONE +1 (800) 808 2694
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