iMed Medical 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 your medical provider.**

Please note that all sections 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.

ATTACH ALL INVOICES AND RECEIPTS AND SUBMIT YOUR CLAIM BY EMAIL TO:
mshclaims@mshassistance.com

OR SUBMIT YOUR CLAIM BY MAIL TO:
MSH Assistance™
150 King St West, Suite 602
PO Box 75,
Toronto ON M5H 1J9

+1.800.808.2694
toll-free from Canada and the USA

+1.403.538.2364
collect where available

INSURED & PATIENT INFORMATION

PRIMARY INSURED INFORMATION (THE INTERNATIONAL STUDENT/INTERN)

Name of School	Group Policy Number	Member Policy Number
UBC - iMed		

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:

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:

EXPENSES CLAIMED

Name of Medical Provider	Reason for visiting the doctor & Diagnosis	Date of Service (DD/MM/YY)	Amount Billed ($)	Amount Paid ($)

EXPENSES CLAIMED CONT'D

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:

CLAIM PAYMENT INFORMATION

THIS CLAIM IS PAYABLE TO:

Last Name | First Name

Unit # | Street

City | State/Province | Country | ZIP / Postal Code

Phone Number | Email Address

SELECT A PAYMENT METHOD

☐ Cheque payment by mail* ☐ Wire transfer** ☐ Electronic Funds Transfer (complete fields below. **Example here.**)

* 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 Name | Payee Email Address | Beneficiary Bank Name

Beneficiary Address

Bank Address

FOR CANADIAN BANKS ONLY

Transit Number (5 digits only) | Financial Institution (3 digits only) | Account Number (7 digits only)

FOR NON-CANADIAN BANKS

Bank Identification Number | Beneficiary Account Number | ABA Code (Accounts in USA only) | SWIFT Code (All other Non-Canadian banks)

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 of 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 150 King St. W. Suite 602 - PO Box 75, Toronto, Ontario, Canada M5H 1J9**
FAX **+1 (416) 730 1878** | EMAIL **mshclaims@mshassistance.com** | TOLL-FREE PHONE **+1 (800) 808 2694**

MSH International recognizes and respects the importance of privacy. When you submit a claim, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information for the purpose of assessing your claim and administering the group benefits plan. Personal information is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act.