CLAIM FORM

GLOBAL CAMPUS HEALTH PLAN - **ADVANTAGE PLAN**

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 the **Claim Payment Information** section 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 and certificate number on your insurance ID card.

INSURED & PATIENT INFORMATION

PRIMARY INSURED INFORMATION (THE INTERNATIONAL STUDENT/INTERN)

Name of School | Certificate Number (on Insurance ID Card) | Policy Number (on Insurance ID Card)

Last Name | First Name

Sex: ☐ Male ☐ Female | 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

Sex: ☐ Male ☐ Female | 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

Unit # | Street

City | 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 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 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

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.