



# EMERGENCY OUT-OF-COUNTRY CLAIM

Suite 700 Weber Centre  
5555 Calgary Trail  
Edmonton | Alberta | T6H 5P9  
Phone: 1-877-431-4786  
www.asebp.ab.ca

Please answer all questions to support timely processing of your claim

1. **Submit original receipts and documentation.** Photocopies or faxed invoices are not accepted. Cash register receipts will not be accepted unless accompanied by an itemized account, pharmacy receipt or physician order. Paid receipts must include the name of the person claiming the expense.
2. **Complete all sections of this form.** Please complete a **separate form** for each person.
3. **For reimbursement of services already paid:** Please provide proof of payment (paid receipt or copy of cancelled cheque – both sides). In accordance with your plan, claims for expenses must be received by Alberta School Employee Benefit Plan (ASEBP) **within 18 months** from the date of service in order to be eligible.
4. **Claimants who are not Alberta residents:** Submit all hospital and physician claims **first** to the claimant's provincial health plan for assessment, **then** to ASEBP.

## A. Covered member information (Refer to your ASEBP ID card)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Home phone number: (\_\_\_\_) \_\_\_\_\_  
 Mailing address: \_\_\_\_\_ Work phone number: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_  
 Provincial Health Number: \_\_\_\_\_ ASEBP Member ID No: 

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## B. Patient information (Please provide a separate form for each person)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Provincial Health Number: \_\_\_\_\_ ASEBP ID #: \_\_\_\_\_ Relationship to covered member: \_\_\_\_\_  
 Reason for travel:  Vacation  Business  School  Treatment  
 Date of departure: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of actual return: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of intended return: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## C. Claim information

Diagnosis (Reason for seeking treatment) _____	Country claim occurred in? _____	Currency claim occurred in? _____	Have you already paid for this service? <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Type of product or service</u>	<u>Who provided the product or service?</u>	<u>Date of service (YYYY/MM/DD)</u>	<u>Amount claimed</u>
<input type="checkbox"/> Ambulance _____	_____	_____ / _____ / _____	_____
<input type="checkbox"/> Prescription Drugs _____	_____	_____ / _____ / _____	_____
<input type="checkbox"/> Physician Services _____	_____	_____ / _____ / _____	_____
<input type="checkbox"/> Hospital _____	_____	_____ / _____ / _____	_____
<input type="checkbox"/> Transportation _____	_____	_____ / _____ / _____	_____
<input type="checkbox"/> Other: Meals and Accommodation, Vehicle Return, Funeral/Returned of Deceased (Please provide details) _____			

If this claim is due to an accident, please complete below:

Date of Accident: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Type & location of accident: \_\_\_\_\_

Has a claim been made to recover damages from the responsible person(s)?  Yes  No If no, do you intend to make a claim?  Yes  No

## D. Other insurance coverage (Please complete this section if you have coverage through another insurance plan)

Other ASEBP Plan or Name of other Insurance plan: \_\_\_\_\_  
 Policy No.: \_\_\_\_\_ ID No.: \_\_\_\_\_ Name & date of birth of covered member: \_\_\_\_\_

## E. Consent for the collection, use and disclosure of personal information

The personal information contained in this claim form and supporting documentation as well as other personal information held by ASEBP is used to determine eligibility of this benefit, verify, assess and pay claims and administer your group benefit plan.

I hereby authorize any licensed physician, other health care professionals or institutions, health benefits or insurance companies, government or regulatory authorities or third parties to release pertinent records, information or payments to ASEBP for the purposes described above. I also authorize ASEBP to release pertinent records, information or payments to other health benefit or insurance companies for the same purpose. I certify that the information contained in this claim and supporting documentation is true, accurate and complete.

\_\_\_\_\_  
 Patient's or Guardian's (if minor) Signature Covered Member's Signature Date (YYYY/MM/DD)