

# Provincial Health Alternative Student Insurance Claims Information Sheet

*This document addresses frequently asked questions  
related to In-Province Hospital Medical Insurance claims*

## **MEDICAL CLAIMS**

- The Provincial Health Alternative Insurance claim form must be completed in full in order to process your claim.
- Please be sure that all Paramedical Services, x-ray, or Laboratory Fees are reported in **Section A – Paramedical Services**.
- Please ensure that **Section B – Physician Account Record** is completed by the attending physician (MD).
- Please ensure to attach all Original Invoices or Receipts.

## **DENTAL INJURY OR DENTAL EMERGENCY CLAIMS**

- The Provincial Health Alternative Insurance claim form must be completed in full in order to process your claim.
- Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident or emergency related dental treatment received.
- Please ensure that **Section C – Dental** is fully completed by your Dental Provider.

## **IMPORTANT**

- The Provincial Health Alternative Insurance claim form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company") within 90 days of the date of the accident or commencement of sickness, regardless of whether expenses have been incurred. Attach only original receipts for all expenses being claimed.
- If your claim is for emergency medical expenses incurred out of your province of residence, please contact our office for the necessary Claim Forms.

## **WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED...**

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 1-3 weeks. Our response would be one of the following:

*(A) Payment or Notification of Payment to a Provider*

*(B) Request for more information if required*

*(C) Acceptance or Denial of the claim with reasons*

Return completed claim form to:  
**INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.**  
Life and Health Claims Department, Special Markets Solutions  
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6  
Tel: 1-800-549-7227  
[www.solutionsinsurance.com](http://www.solutionsinsurance.com)

In providing this claim form for the convenience of the claimant, the Company does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.



Life and Health Claims Dept.  
 Special Markets Solutions  
 2165 Broadway W, PO Box 5900  
 Vancouver, BC V6B 5H6  
 Tel: 1-800-549-7227

# Provincial Health Alternative Student Insurance

Please print in ink

School or College Name	Policy Number
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Student's Last Name	Student's First Name
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Student's Date of Birth <input type="text"/> <small>( D D / M M M / Y Y Y Y )</small>
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Patient's Last Name	Patient's First Name
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Student <input type="checkbox"/> Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Patient's Date of Birth <input type="text"/> <small>( D D / M M M / Y Y Y Y )</small>
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Full Address in Canada:

Street

City	Province	Postal Code	Phone Number
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**(A) This section to be completed if claiming for Paramedical Services, X-rays, or Laboratory Fees**

Are any benefits or services provided under any other group insurance or plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Insuring Company <input style="width:100%;" type="text"/>
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If "Yes", have you claimed these expenses to them? Yes  No

Please enter the total amount claimed for Paramedical Services, X-rays, or Laboratory Fees: \$

Should benefits be payable, please select the following:

Cheque should be payable to:  Insured **OR**  Other (indicate below)

Last Name	First Name
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Address:

Street

City	Province	Postal Code	Phone Number
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**Authorization and Declaration**

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information which the Company may need in their assessment of this claim.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Date Signed <input style="width:100%;" type="text"/> <small>( D D / M M M / Y Y Y Y )</small>	Signature of Parent, or Legal Guardian or Insured <input style="width:100%;" type="text"/>
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**PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS**

