# VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

#### Ontime Care Worldwide Inc.

15 Wertheim Court, Suite 512 Richmond Hill, Ontario L4B 3H7 Collect worldwide: 905-707-9555 Toll free Canada/U.S.A.: 1-866-209-5804

## **INSTRUCTIONS**

### **IMPORTANT**

- In the event of hospitalization, Ontime Care Worldwide Inc. (OTC) must be notified prior to, or within 24 hours of admission to hospital and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.

### REQUIREMENTS

- Fully completed and signed Claim Form, sections A, B, C & D.
- Emergency room report and/or hospital records if treated at a hospital/outpatient facility.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.

### **CLINIC SERVICES**

- Visitors should go to the nearest clinic, medical centre, or family physician.
- Before leaving the medical service provider, the visitor should obtain a copy of the Physician's medical report. (If any major tests or procedures are to be performed, the visitor must contact Ontime Care Worldwide Inc. for coverage information before proceeding.)
- If the visitor has paid for the services up front, they must obtain a payment receipt for the visit and a pharmacy receipt for any prescription medications (there is no coverage for nonprescription or over-the-counter medications, and we do not reimburse the fees to obtain medical report if one is charged).
- Send in a signed & completed Claim Form, Consent Form, the physician's report(s), original bill(s) and payment receipt(s) to the address on your claim form. If a prescription was filled, be sure to provide the original prescription pharmacy receipt that indicates the medication information and the prescription doctor's information.

SECTION A: CLAIMANT INFORMATIO	N			
Insured's First Name:		Last Name:		
☐ Male ☐ Female Da	te of Birth: MM/DD/YYYY	Policy #:		
Address in Canada				
Street Address:				
City/Town:		Postal Code:		
Telephone: ( )		Email:		
Country of Origin:		Date of Arrival in Canada: MM/DD/YYYY		
Name and Address of Family Physician in Country of Origin		Name:		
Street Address:				
City/Town:		Postal Code:	elephone: ( )	)
Name and Address of Family Physician i	n Canada	Name:		
Street Address:				
City/Town:		Postal Code:	elephone: ( )	)
Do you have other insurance coverage in	cluding Canadian government hea	lth insurance? Yes No		
Do you have insurance coverage through	your spouse? Yes No			
If 'Yes', please provide name and address	s of other insurance company/cov	erage:		
Name:				
Street Address:				
City/Town:		Postal Code:	elephone: (	)
SECTION B: MEDICAL INFORMATION				
Brief description of sickness or injury:				
Brief description of sickness or injury:				
Date symptoms or injury first appeared:	MM/DD/YYYY Dat	e you first saw physician for th	is condition: MM	/DD/YYYY
			is condition: MM	/DD/YYYY
Date symptoms or injury first appeared:	similar condition before? 🔲 Yes 🗌	No		/ D D / Y Y Y Y
Date symptoms or injury first appeared: Have you ever been treated for this or a solid stream of the solid	similar condition before?	No		/ D D / Y Y Y Y
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