Reset

OTIP RAEO®

OTIP Health Claims
PO Box 280
Waterloo, ON N2J 4A7

1.866.783.6847 | www.otip.com

Out-of-Province/ Out-of-Canada Health Claim

(For physician's fees and hospital services only)

INSTRUCTIONS: (Please PRINT CLEARLY.)

- All sections to be completed by the plan member unless otherwise indicated.
- **One form must be completed for each patient.**
- Claims MUST be submitted to your provincial plan and THEN submitted to OTIP Health Claims with a copy of the statement of payment (or decline).
- The group benefits insurance carrier ("Insurer") will co-ordinate claim assessments on your behalf when you have individual travel health insurance coverage.
- Please attach copies of itemized statements from the provider of services to the BACK of this form. These will not be returned.
- Eligible expenses submitted in a foreign currency will be paid in Canadian funds.
- ANY COST INCURRED AS A RESULT OF OBTAINING ANY ADDITIONAL INFORMATION THAT IS REQUIRED BY OTIP OR THE INSURER IS THE RESPONSIBILITY OF THE PLAN MEMBER.

SECTION 1: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Gender ☐ Male ☐ Female
Address (Number, Street and Apt.)		City/Town	Province / Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*	Plan Sponsor
OTIP Identification Number	Plan Number	Email Address	

SECTION 2: PATIENT INFORMATION (Complete for all expenses.)

Patient's Name	Date of Birth (mm/dd/yyyy) (1st Claim Only)	Relationship to Plan Member (1st Claim Only)	Complete if patient is a student, 18 or older	
			School and City	If employed, hours worked per week

Are these expenses eligible for coverage under any type of worker's compensation? ☐ Yes ☐ No

Is the patient covered under any other travel or group insurance plan for the expenses being claimed? ☐ Yes ☐ No

If "**Yes**", please provide the following information:

Name and address of insurance company	Type of Policy	Plan Contract Number	Plan Member Number	Name of person(s) policy issued to
1	☐ Ind.* ☐ Group*			
2	☐ Ind.* ☐ Group*			
3	☐ Ind.* ☐ Group*			
4	☐ Ind.* ☐ Group*			

* "Ind." refers to travel insurance purchased by the individual/family. "Group" refers to benefits provided through plan sponsor.

SECTION 3: CLAIM INFORMATION

EMERGENCY CARE: Treatment for an injury which occurs or an illness which begins while temporarily outside of province/Canada.

Date of Departure *(mm/dd/yyyy)*	Date of Return *(mm/dd/yyyy)*	Province/Country where treatment was provided

1. Describe when, how and where the injury/illness occurred.

SECTION 3: CLAIM INFORMATION (CONTINUED)

2. Was the patient previously treated for this condition any time prior to leaving the province or Canada? ☐ Yes ☐ No
   If **"Yes"**, please attach a letter from the treating Canadian physician stating the previous treatment rendered.

3. Did you receive a discount from the provider of service for any of the bills/invoices submitted? ☐ Yes ☐ No
   If **"Yes"**, please submit original discounted bills/invoices for processing.

Additional comments regarding the Emergency Care Claim:

SECTION 4: CERTIFICATION AND AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. I authorize OTIP and the group benefits insurance carrier ("Insurer") that provides my benefits coverage to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

Signature of Plan Member **Date (mm/dd/yyyy)**

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- The Insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to personal information in your file, and where appropriate, to have any inaccurate information corrected.

SECTION 5: MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

OTIP Health Claims
PO Box 280
Waterloo ON N2J 4A7

QUESTIONS?

OTIP Benefits Services
1-866-783-6847

Direct Deposit

Receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Visit www.otip.com and log in. Once you have logged in to 'My Claims', choose **My profile** from the top navigation, then **Update banking information.** First-time users, you will need to complete registration.