Yukon
Health and Social Services

OUT-OF-COUNTRY CLAIMS

TO BE FILLED OUT BY THE BENEFICIARY

IMPORTANT

1. Please read **Section D** before completing this form.
2. Attach all original receipts or bills to this form, include itemized statement. Receipts not in English or French must be translated before being submitted.
3. Claims must be received within 6 months from date of service.
4. This three-part form must be completed in full and signed by the patient or their legal guardian.
5. Retain copies of bills or receipts for your own records.
6. If you leave Canada specifically to obtain medical care, you must receive prior approval for payment.

SECTION A – PATIENT INFORMATION

LAST NAME	FIRST NAME	PERSONAL HEALTH NUMBER (PHN)
BIRTHDATE YYYY / MM / DD	**PHONE NUMBER** (day) (home/cell)	**EMAIL ADDRESS**

MAILING ADDRESS	CITY	PROV/TERR	POSTAL CODE

REASON FOR ABSENCE FROM YUKON

- ☐ Vacation
- ☐ Moved
- ☐ Business trip
- ☐ Obtain medical care
- ☐ Student
- ☐ Other (specify):

DEPARTURE DATE FROM YUKON
YYYY / MM / DD

RETURN DATE TO YUKON
YYYY / MM / DD

DO YOU HAVE PRIVATE OR TRAVEL INSURANCE?
☐ Yes ☐ No

IF YES, NAME OF COMPANY

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Out-of-Country Claims, Department of Insured Health, to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care.

I, the patient named above, hereby authorize Out-of-Country Claims, Department of Insured Health, to obtain information to/from the above named travel insurance or extended health benefits company.

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

_____
SIGNATURE OF PATIENT / LEGAL GUARDIAN

YYYY / MM / DD
_____
DATE SIGNED

If legal guardian, provide name and relationship to patient.

NAME OF LEGAL GUARDIAN	CONTACT PHONE #
RELATIONSHIP TO PATIENT	

Information is being collected under the authority of the *Health Care Insurance Plan Act* for the purpose of determining eligibility for health care benefits. Personal information on this form is protected under the Yukon's *Access to Information and Protection Act* and the Yukon's *Health Information Privacy and Management Act*, and must be protected, disclosed, collected and used in accordance with these legislations.

SECTION B – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION	
REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS) – *Attach physician's report/notes*	
TREATMENT / PROCEDURE	
DURATION OF ANAESTHESIA *(if applicable)* _____ Hrs _____ Mins **OR** From _____ to _____	
LABORATORY TESTS *(if applicable)*	AMOUNT PAID – *enclose proof* $ _____
SPECIFY EACH AREA X-RAYED *(if applicable)*	AMOUNT PAID – *enclose proof* $ _____

PHYSICIAN INFORMATION FOR EACH ENCOUNTER – *enclose proof of PYMT*			
1	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____
2	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____
3	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____
4	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____
5	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____
6	DOCTOR'S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT ☐ 8am–6pm ☐ 6pm–11pm ☐ 11pm–8am	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No
	TYPE OF VISIT ☐ Office ☐ Home ☐ Hospital		AMOUNT PAID $ _____

Attach additional page if necessary

SECTION C – TO CLAIM FOR HOSPITAL CHARGES COMPLETE THIS SECTION

1. Hospital charges are inclusive of all services.
2. Hospital must be publicly funded.
3. Coverage is paid at the regular ward rate.

NAME OF HOSPITAL		
MAILING ADDRESS OF HOSPITAL		
DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION		
DATE OF ADMISSION YYYY / MM / DD	DATE OF DISCHARGE YYYY / MM / DD	HAVE YOU PAID THE ACCOUNT? ☐ Yes ☐ No

SECTION D – GENERAL INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible Yukon resident is temporarily absent from the territory and must use emergency medical services in another country, the rates are paid at the Yukon physician and hospital rates. Any difference in fees will be the beneficiary's responsibility.

Reimbursement will not be paid for services provided in private facilities, ambulance or air-medivac.

FORMS CAN BE RETURNED VIA:

FAX:
867-393-6486

MAIL:
Insured Health Services Dept. H-2
P.O.Box 2703
Whitehorse, Yukon Y1A 2C6

IN PERSON:
204 Lambert St. 4th Floor
Whitehorse, Yukon

For more information on coverage outside of Yukon, visit the website at:
www.hss.gov.yk.ca/yhcip-coverage.php

If you require further information, contact Department of Insured Health at:
867-667-5209

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