

**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		DEPARTURE DATE FROM YUKON YYYY / MM / DD
<input type="checkbox"/> Vacation <input type="checkbox"/> Obtain medical care <input type="checkbox"/> Moved <input type="checkbox"/> Student <input type="checkbox"/> Business trip <input type="checkbox"/> Other (specify):		RETURN DATE TO YUKON YYYY / MM / DD
DO YOU HAVE PRIVATE OR TRAVEL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<i>If legal guardian, provide name and relationship to patient.</i>	
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 <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____
2	DOCTOR’S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____
3	DOCTOR’S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____
4	DOCTOR’S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____
5	DOCTOR’S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____
6	DOCTOR’S NAME AND SPECIALTY		COUNTRY AND CURRENCY
	DATE OF VISIT YYYY / MM / DD	TIME OF VISIT <input type="checkbox"/> 8am–6pm <input type="checkbox"/> 6pm–11pm <input type="checkbox"/> 11pm–8am	HAVE YOU PAID THE ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TYPE OF VISIT <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital		AMOUNT PAID \$ _____

**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](http://www.hss.gov.yk.ca/yhcip-coverage.php)

If you require further information, contact Department of Insured Health at:

**867-667-5209**