



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

MEDICAL CLAIMS

- The Provincial Health Replacement Insurance claim form must be completed in full in order to process your claim.
- Please be sure that all prescription Drugs, Paramedical Services, x-ray, or Laboratory Fees are reported in **Section A**.
- Please be sure that all HOSPITAL, MEDICAL EXPENSES or PHYSICIAN'S SERVICES are reported in **Section B -Physician's Account Record** section on Page 2 which must be completed by the attending physician (MD). Chiropractors, Physiotherapists, Registered Nurses, or any other service providers are **not eligible** to complete the form.

DENTAL INJURY CLAIMS

- The Provincial Health Replacement Insurance claim form must be completed in full in order to process your claim. If claiming for dental injury, please be sure that Page 1 and **Section C- Dental Injury Section** on Page 2 of the claim form are completed.
- Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident related dental treatment received.

IMPORTANT

- The Provincial Health Replacement Insurance claim form must be filed with Industrial-Alliance Pacific Life Insurance Company within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all expenses being claimed.

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 depending on claims volume. 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 PACIFIC LIFE INSURANCE COMPANY
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-556-7411
www.iaplif.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.

Group Name <div style="border: 1px solid black; padding: 2px; text-align: center;">Calgary Board of Education</div>	Policy Number <div style="border: 1px solid black; padding: 2px; text-align: center;">100006331</div>
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Insured's Last Name <div style="border: 1px solid black; height: 20px;"></div>	Insured's First Name <div style="border: 1px solid black; height: 20px;"></div>
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Sex	Date of Birth																																		
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Patient's Last Name <div style="border: 1px solid black; height: 20px;"></div>	Patient's First Name <div style="border: 1px solid black; height: 20px;"></div>
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Full Address in Canada	Phone Number
Street	
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

City	Prov.	Postal Code	Type of Coverage:
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>	<input type="checkbox"/> Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

A. This section to be completed if claiming for Prescription Drugs, Paramedical Services, X-rays, or Laboratory Fees

Date Service Rendered (D D / M M M / Y Y Y Y)	Nature of Illness or Injury	Claim Description	Amount Charged	Name of Doctor Prescribing Service	Date First Consulted for Condition (D D / M M M / Y Y Y Y)

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

Name

Address	Phone Number
Street	
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
City	Prov. Postal Code
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

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 Pacific Life Insurance Company ("IAP") 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 IAP any medical information, information regarding charges, or other information which IAP may need in their assessment of this claim.

I AUTHORIZE IAP 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.

Claimant's Signature <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Date: <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> <tr> <td>(</td><td>D</td><td>)</td><td>(</td><td>D</td><td>)</td><td>(</td><td>M</td><td>)</td><td>(</td><td>M</td><td>)</td><td>(</td><td>Y</td><td>)</td><td>(</td><td>Y</td><td>)</td><td>(</td><td>Y</td><td>)</td><td>(</td><td>Y</td><td>)</td> </tr> </table>											(D)	(D)	(M)	(M)	(Y)	(Y)	(Y)	(Y)
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PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS

See reverse side for Physician's Statement ➔

