MEDICAL CLAIM FORM

MSH INTERNATIONAL 2020

INSTRUCTIONS

- Please ensure that all areas of this form are completed in full to avoid any delays in your reimbursements;
- Claims submissions by fax or email may be available under your benefit plan. Please refer to your benefit booklet or policy for more details on submission availability and limitations;
- All claims must be received by MSH INTERNATIONAL within the required time limit following the date the expense was incurred. Please refer to your benefit booklet for confirmation of your time limit for submitting claims.
- No claims will be paid, directly or indirectly, in contravention of any restrictions imposed for example by the United Nations, the Office of Foreign Assets Control (OFAC) from the U.S. Department of the Treasury or the European Union, in respect of countries subject to sanctions.

SECTION A: CLAIMAINT

First Name | Last Name | Middle Initial

Date of Birth (MM/DD/YYYY) | Certificate Number

Address

City | Province/State | ZIP/Postal Code | Country

Phone Number | Email address

Is the treatment due to an accident? ☐ Yes ☐ No

If Yes, may another person be responsible? ☐ Yes ☐ No

MANDATORY SECTION

Do you have any other insurance coverage? ☐ Yes ☐ No

Are you currently making a claim with that insurer? ☐ Yes ☐ No

If yes, provide name and address of insurer and the policy number:

Name | Address | Policy number

SECTION B: SPOUSE & DEPENDENT(S)

Complete for all Dependents being claimed for on this form, if applicable. If your Dependent Child is considered Over Age, please indicate if they are full-time student or disabled. If they are a full-time student please submit confirmation of enrolment. Please refer to your benefit booklet or policy for Dependent eligibility requirements.

Patient Name	Relationship to Primary Insured	Date of Birth (MM/DD/YYYY)	Full-time Student	Physical or Mental Disability?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL SERVICES: Please use a separate claim form for additional medical services, if necessary. Completion of diagnosis/reason for treatment is mandatory. Failure to complete this section will result in delays of claims reimbursement.

Patient Name	Date of Service (MM/DD/YYYY)	Service Type/ Name of Drugs (doctor visit, hospitalization, etc.)	Diagnosis/ Reason for Treatment	Is this your primary consultation/ treatment?	Amount Charged
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
TOTAL AMOUNT CLAIMED FOR MEDICAL SERVICES (INCLUDING CURRENCY):					

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TO BE COMPLETED BY PHYSICIAN

Attach original receipts. Physician statement is required if attached receipts do not include adequate information of the illness, injury and/or for treatment received. Attach additional notes if necessary.

Physician's Name: Signature: Date (MM/DD/YYYY):

SECTION C: ASSIGNMENT OF BENEFITS

If you are authorizing reimbursement to another party, please complete this section. Failure to complete this section will result in reimbursement being made according to the current information available on file.

Name of Party Signature of Primary Insured: Date (MM/DD/YYYY):

SECTION D: CLAIM PAYMENT INFORMATION

I understand it is my responsibility to advise MSH INTERNATIONAL of any changes in banking information. Please indicate if you would prefer to receive your claim payments via:

☐ Cheque

Please confirm currency of claim reimbursements: _____

(Note: you will be notified if we are unable to process your currency of choice)

☐ Wire Transfer

For wire transfer payments, please attach a void cheque and provide your the bank account details as required by the receiving bank.

BANK INFORMATION

Beneficiary Bank Name	Bank Identification Number	
Address of Beneficiary Bank	Currency of Bank Account	SWIFT

BENEFICIARY INFORMATION

Beneficiary Name	Beneficiary Account Number	
Beneficiary Address	ABA Code (USA)	SWIFT

Please note, your bank may charge you fees to receive a wire transfer. Any fees charged by the receiving bank are the responsibility of the beneficiary.

SECTION E: AUTHORIZATION AND CERTIFICATION

☐ I hereby warrant the truth of all statements on this form and give MSH INTERNATIONAL permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of these claims. I also give MSH INTERNATIONAL permission to send communications pertaining to my claims and the administration of my group benefits plan to the email I supply on this claim form.

Signature of Insured Member: _____ Date (MM/DD/YYYY): _____

At MSH INTERNATIONAL, we recognize and respect the importance of privacy. When you submit a claim, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information for the purpose of assessing your claim and administering the group benefits plan. Personal information is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act.

SEND CLAIM FORM(S) TO MSH INTERNATIONAL

MSH CANADA
300, 999-8TH S.W.
Calgary, AB T2R 1N7 CANADA

Tel: +1 800 672 6089
Fax: +1 403 265 9425
claimsamerica@msh-intl.com

MSH FRANCE
23 Allées de l'Europe
Clichy 92110 FRANCE

Tel: +33 (0) 1 44 20 82 20
Fax: +33 (0) 1 44 20 99 03
claimsamerica@msh-intl.com

MSH UAE
One by Omnyat, 19th Floor
Business Bay PO Box 506537 UAE

Tel: +971 4 365 1308
Fax: +971 4 363 7327
claimsamerica@msh-intl.com

MSH ASIA
East Unit, 5th Floor North Tower, Building 9
Lujiazui Software Park - No. 20, Lane 91 E Shan Road,
Pudong - Shanghai P. R. CHINA 200127

Tel: +86 21 6187 0595
Fax: +86 21 6160 0153
claimsamerica@msh-intl.com