CAMPUSCARE
International Student Health Insurance Program

OUT PATIENT CLAIM FORM

Form can be sent to ACM via email to CampusCareClaim@active-care.ca or mailed to P.O. Box 1237 Station A Windsor, ON N9A 6P8. Please include all copies of receipts.

SECTION A – CLAIMANT INFORMATION

Patient's Last Name			Patient's First Name	
Policy Number or Student ID Number	School Campus	Date Enrolled in School MM | DD | YYYY	Date of Birth MM | DD | YYYY	Gender ☐ Male ☐ Female
Residence Address	City		Province	Postal Code
Email Address			Phone ( )	

SECTION B – MEDICAL INFORMATION

Physician/Clinic Name		Phone ( )	Fax ( )
Physician/Clinic Address	City/Town	Province	Postal Code

Was this condition related to a pregnancy? ☐ Yes ☐ No	Date of Last Menstrual Period MM | DD | YYYY	Expected Date of Delivery MM | DD | YYYY

Brief Description Presenting Complaint/Symptoms & Diagnosis

Date of Service MM | DD | YYYY

Medical Services Provided

Please provide details of treatment in addition to Consultation

EXPENSE – TO BE COMPLETED BY POLICYHOLDER – for expenses over $300, original receipts must be submitted via mail or by fax.

Provider Name	Description of Expense (ex: pharmacy bill, office visit, etc)	Date of Service	Amount paid	Date paid	Receipt attached?
		MM | DD | YYYY		MM | DD | YYYY	☐ Yes ☐ No
		MM | DD | YYYY		MM | DD | YYYY	☐ Yes ☐ No
		MM | DD | YYYY		MM | DD | YYYY	☐ Yes ☐ No
		MM | DD | YYYY		MM | DD | YYYY	☐ Yes ☐ No

SECTION D – AUTHORIZATION

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with ACM or its representative, any information that is required to process this claim. I assign to ACM any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payers to forward payment directly to ACM. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with ACM. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

I certify that the information provided in connection with this claim is complete, true and accurate.

Policyholder's Signature (If minor, signature of parent or legal guardian)	Date MM | DD | YYYY

ACM is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of ACM's privacy policy, please contact us.