COMPASS INTERNATIONAL
Policy No. 158927

DRUG & MEDICAL CLAIM FORM

Administrator: Cowan
700-1420 Blair Place
Ottawa ON K1J 9L8

Contract Professional's Information *
MUST be completed in FULL, one form per claimant*

Family Name	First Name	Certificate #

Claimant Information – Complete if claiming for insured dependent.

Family Name	First Name	Relationship	Certificate #

Address – where Explanation of Benefits should be sent

Medical Expense – Provide final diagnosis or description of illness, injury, and treatment **(attach original receipts)**

Date of Service	Amount
TOTAL :	

Doctor's / Clinician's Signature

Doctor's/Clinician's Name. Please PRINT and include certifications.

Other Expenses (attach original receipts)

Date of Service (dd/mm/yy)	Description of expense (i.e. x-ray, lab, name of drug)	Amount
	TOTAL :	

Reimbursement – In Canadian funds ONLY (should banking information change, please attach voided cheque)

I wish any reimbursement to be sent to :	- to the above address	☐
	- my Canadian bank account, previously provided	☐

Authorization

I understand that personal information collected from me is kept in strict confidence and will be used to assess my claim and to administer my benefit plan. I hereby authorize Cowan, any licensed physician, medical practitioner, hospital, clinic or other medically related facility, any health care provider, insurance company, pre-payment organization or benefit service provider working with Cowan to exchange information when necessary to assess this claim. A photocopy of this authorization shall be as valid as the original. I certify that the information given on this form is true, correct and complete to the best of my knowledge.

Signature of Contract Professional _____ Date _____

** **Important: Ontario residents who have maintained their OHIP coverage please complete the back of the claim form**.

Cowan

AUTHORIZATION AND RELEASE
(Consent for Self)

I, _____ irrevocably direct and authorize the Ontario Ministry of Health and Long Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to Cowan directly and hereby release OHIP upon payment to Cowan from any further claim or cause of action in connection therewith.

I authorize the Ministry to collect my personal health information, consisting of:

- ► information relating to my receipt of health care services outside of Canada, and
- ► information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from Cowan, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including details of any duplicate payment previously made to me to Cowan.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Please provide us your Ontario provincial health card number: _____.

AUTHORIZATION:

My Name: _____ Address: _____

Home Tel: _____ Work Tel: _____

Signature:_____ Date: _____

Witness Name: _____ Address: _____

Home Tel: _____ Work Tel: _____

Signature: _____ Date: _____

Cowan

AUTHORIZATION AND RELEASE
(Consent on behalf of Insured Person Not Capable to Consent)

I, _____ am the substitute decision-maker* for _____ (name of Insured Person for whom you are the substitute decision-maker) I irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect to the Insured Person for Out-of-Country health services to Cowan directly and hereby release the Ministry, upon payment to Cowan from any further claim or cause of action in connection therewith.

I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

- ► information relating to the Insured Person's receipt of health care services outside of Canada, and
- ► information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from Cowan, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying the Insured Person's request for payment under the Health Insurance Act, including details of any duplicate payment previously made to the Insured Person, to Cowan.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Please provide us your Ontario provincial health card number: _____.

AUTHORIZATION:

My Name: _____ Address: _____

Home Tel: _____ Work Tel: _____

Signature: _____ Date: _____

Witness Name: _____ Address: _____

Home Tel: _____ Work Tel: _____

Signature: _____ Date: _____

* **Note:** A substitute decision-maker is a person authorized under the Personal Health Information Protection Act (PHIPA) to consent, on behalf of an individual, to disclose personal health information about the individual.