MYCARE - ASSURED DIAGNOSIS INC.

NOTICE OF CLAIM FORM

IDENTIFICATION

Name First Name _____ Last Name _____ Middle Initial(s) _____

Mailing Address _____

City _____ **Province** _____ **Postal Code** _____

Phone Day _____ Evening _____ **Email** _____

Date of Birth (MM/DD/YY) _____ **Gender** ☐ Male ☐ Female **Provincial Health Plan Coverage?** ☐ Yes ☐ No

Policy or Certificate Number: _____ *Your identification number(s) must be included.*

Provincial Healthcare Number: _____ **Driver's License Number (if applicable):** _____

EMPLOYER INFORMATION (MYCARE HBO ONLY)

Employer Name: _____

Mailing Address: _____

Phone: _____ **MyCare HBO Plan Number:** _____ *Policy number must be included; If unknown, please check with employer*

INTERVIEW ARRANGEMENTS

Please indicate the times or dates when a telephone interview about your claim would be most convenient for you. (Please note that it may be determined that a telephone interview is not required).

Date	Time	Phone Number	Time Zone	Alternate Date	Time	Phone Number	Time Zone

If a telephone interview is not possible, please explain why: _____

CLAIM INFORMATION

What is the nature of your condition: _____

If the condition is due to an accident, please provide the date the accident occurred: Year _____ Month _____ Day _____

Where and how did the accident occur? _____

Was the accident work related? ☐ Yes ☐ No

Name and Phone Number of physician currently supervising your treatment: _____

Names and Phone Numbers of other physicians you have seen for treatment or diagnostics related to this condition:

Continued...

CLAIM INFORMATION - continued

Were you confined to a hospital? ❑ Yes ❑ No **If yes, please complete the following:**

Hospital Name	Hospital Address	Date: From	Date: To

PRESENT CLINICAL HISTORY

What tests have you had to aid the diagnosis of your present condition? (i.e., ECG, CT Scan, Xrays, etc.): _____

_____

What tests or surgical procedures have been recommended? _____

_____

Has the referring physician placed you on a wait list that is more than 60 days long? ❑ Yes ❑ No

If yes, please list the facility or clinic, name of the physician and date of appointment: _____

_____

CLAIMS PROCESS and SUBMISSION INSTRUCTIONS

MyCare Health Benefit Option (HBO) nor MyCare Advantage Insurance are not intended to replace services available in the Canadian public healthcare system. MyCare members may request Initial Diagnosis Assistance or a medical second opinion when their attending Primary Care Physician (PCP) or attending Specialist have a documented medical reason to suspect a Serious Illness, as defined by the Certificate, may exist and has not been diagnosed within sixty (60) days of the first evaluation. If a Serious Illness is suspected, then notice must be given to MyCare via the Notice of Claim form and submitted as instructed below. Once received, MyCare's medical team will review the form to ensure claim validity and/or gather any pertinent medical information. Upon review of this information, a MyCare claims coordinator will contact you to discuss possible next steps.

Fax a copy of this form to 1-877-247-9891 or email a scanned copy to: claims@mycare.ca
Please direct any questions to MyCare Claims at 1-877-497-9495.

AUTHORIZATION

I have read the MyCare Health Benefit Option Certificate and the MyCare Advantage Insurance Policy (if applicable) related to a claim submission and the Pre-Exisiting Condition Clause and understand that a claim will not proceed until reviewed and approved by MyCare. I further understand that a claim must adhere to the definition of a Serious Illness in order to proceed. I hereby authorize Assured Diagnosis Inc. ("ADI"), the owner and developer of the MyCare programs, and/or Global Benefits Administrators ("GBA"), the coverholder for MyCare Advantage Insurance, or their representative(s) to release all medical information including but not limited to all diagnostic and treatment reports, test results and treatment recommendations to my family physician and/or attending Canadian physician(s). I also authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsurance company, government health insurance plan or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named minor children and other non-medical information of me or my named minor children, to give to ADI and/or GBA or their legal representative any and all such information. Any information obtained will not be released by ADI and/or GBA to any person or organization except to insuring or reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment.

I confirm that: I have read the above Authorization and consent to the collection, use and disclosure of my personal information including personal information about my dependent(s) required for claims processing and ongoing administration of the plan.

Applicant Signature **(must always sign)**	Applicant Full Name (print)	Date Signed (MM/DD/YY)