

Out-of-Country Health Services Committee

- A. All information requested must be provided to fulfill the requirements of a complete application. If an application is incomplete, it will not be forwarded to the Out-of-Country Health Services Committee and the Chair will contact you to request the missing information.
- B. Provide a letter of support from your Alberta physician or dentist.
- C. Attach written copies of all relevant diagnostic tests. Tests must be provided from a physician qualified to interpret the results.
- D. The information required for a complete application may also be provided in letter format with necessary attachments.

Section A - Applicant Information						
Note: It is the applicant's responsibility to ensure all requested and relevant information is submitted to the Committee.						
Last name (in full)	First name (in full)			Relationship to patient		
Address				City		
Province/Territory	Postal code	Home phone	Business / Daytime phone	Personal Health Number		
Section B - Patient Information (if not the applicant)						
Last name (in full)	First name (in full)			Middle Initial	<input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (yyyy/mm/dd)
Address				City		
Province/Territory	Postal code	Home phone	Business / Daytime phone	Personal Health Number		
Section C - Referring Physician or Dentist						
Last name (in full)	First name (in full)			Specialty		
Office address						
Office phone number			Office fax number			
Section D - Clinical / Medical Information						
Fill in the following sections and/or attach relevant information to this form. Applicants should not include invoices, receipts or any other information related to the costs of out-of-country services obtained by the applicant.						
Medical condition / problem for which this application is seeking funding:						
Previous consultations and/or treatment(s) relevant to this application, including dates and locations or treatment(s) and any diagnostic test(s):						

Section D - Clinical / Medical Information Cont'd.

Description of requested services:

Expected duration of initial out-of-country treatment(s) (if elective services) OR duration of out-of-country treatments (if non-elective services for which reimbursement is sought):

Number and frequency of expected out-of-country follow-up visit(s), if applicable:

Section E - Out-of-Country Health Facility

Facility name		Address	
City	State	Country	Out of country physician

Why has this particular program, facility or specialist been chosen?

Section F - Resources

Have resources in Alberta and Canada been fully utilized? If not, why?

Section G - Declaration

I certify that the information provided on this form is true and correct to the best of my knowledge.

Applicant's Signature

Date (yyyy/mm/dd)

Submit this form, along with copies of diagnostic test(s) and any other pertinent information, to:

Committee Chair, Out-of-Country Health Services Committee
10025 Jasper Ave NW
PO Box 1360 Stn Main
Edmonton AB T5J 2N3
Fax: 780-415-0963

If you require further information, please write to the Committee Chair at the above address or telephone 780-415-8744. To call toll-free in Alberta, dial 310-0000, then 780-415-8744.

Note: Information collected is used by the Out-of-Country Health Services Committee to consider the patient's eligibility for coverage. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*, and under the *Out-of-Country Health Services Regulation*.