Government of Alberta

Declaration of Hospital Insurance Coverage

In-Patient Interprovincial Agreement

Patient Identification (Provide information as shown on Health Insurance Card)

Surname | **Given Name(s)** | **Initials**

Date of Birth Year Month Day

Address registered with Province of Coverage (R.R #, Number and Street, Apartment No.)

Gender ☐ Male ☐ Female

(City, Town, Village) | **Postal Code**

Current Telephone Number

Province of Coverage

Health Insurance Number

Date of Effectiveness Year Month Day

Date of Expiry Year Month Day

To Be Completed if Patient is Temporarily Present in Host Province

Temporary Address in Host Province *if available* (R.R #, Number and Street, Apt. No., City, Town, Village) | **Province** | **Postal Code** | **Telephone Number**

Reason for entitlement to insured in-patient hospital services from Province of Coverage:

☐ Vacation/In Transit ☐ Study _____ Name of Educational Institution

☐ Medical Referral

☐ Temporary Employment/Business ☐ Other _____ Please Specify

Anticipated Duration of Stay

From Year Month Day To Year Month Day

☐ Awaiting Eligibility for Coverage in the Province *(other than Host Province)* of _____ Date registered with new Health Insurance Plan _____/_____ Year Month

Address registered with Province of Coverage (R.R #, Number and Street, Apt. No., City, Town, Village) | Postal Code | **Telephone Number**

To Be Completed if Patient has Made a Permanent Move to Host Province

Permanent Address in Host Province (R.R #, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | **Telephone Number**

Last Address in former Province (R.R #, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | **Former Telephone Number**

Date of Departure from Province of Coverage Year Month Day

☐ **Date of Arrival** or ☐ **Date of Establishing Residence in Host Province** Year Month Day

Hospital

Name | Location

Additional Information

Hospital Number

Admission/Separation Number

Date of Admission Year Month Day

Declaration of Patient or Representative

I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the *Canada Evidence Act,* that I am entitled (or I declare on behalf of the patient that he/she is entitled) to insured hospital services from the Province of Coverage.

X _____ Signature of Person making Declaration

X _____ Witness (Signature of Authorized Hospital Representative)

_____ Date

Name of Declarant if other than Patient *(Please Print)*

Relationship to Patient *(Please specify if other than Parent/Guardian)*

☐ Parent/Guardian

Address of Declarant if other than Patient (R.R #, Number and Street, Apartment No., City, Town, Village, Province) | Postal Code | Telephone Number

☐ Same as patient