Government of Alberta

Declaration of Hospital Insurance Coverage

In-Patient Interprovincial Agreement

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

Province of Coverage

Surname | Given Name(s) | Initials

Date of Birth: Year | Month | Day

Health Insurance Number

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

Gender: ☐ Male ☐ Female

Date of Effectiveness: Year | Month | Day

(City, Town, Village) | Postal Code

Current Telephone Number

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

Hospital Number

Name | Location

Additional Information

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