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Régie de l'assurance maladie Québec

Application for Review

Complete one application for each person age 18 or over.

Section 1 APPLICATION FOR REVIEW

1. ☐ **Health Insurance** (REFER TO APPENDIX A)
2. ☐ **Prescription Drug Insurance** (REFER TO APPENDIX B)
3. ☐ **Intermediate resources**
4. ☐ **Accommodated adults**
5. ☐ **Medical services outside Canada**
6. ☐ **Medical services in Canada** (outside Québec)
7. ☐ **Ostomates**
8. ☐ **External breastforms**
9. ☐ **Orthoses, prostheses, wheelchairs**
10. ☐ **Domestic help**
11. ☐ **Hearing aids, visual aids or ocular prostheses**
12. ☐ **Lymphedema**
13. ☐ **Eyeglasses and contact lenses for children**

If your application relates to a payment authorization for an exceptional medication or to healthcare received in Québec, do not use this form. In those cases, please contact your doctor or the Régie's Service à la clientèle.

Section 2 INFORMATION ON THE PERSON CONCERNED

Last name at birth	First name	Date of birth (YEAR / MONTH / DAY)	Sex
			F ☐ M ☐

Address
Number | Street | Apartment

Municipality	Postal code	Marital status	Health insurance number

Section 3 REASON FOR THE APPLICATION

Please explain why you are applying for a review and supply all useful documents. (Refer to the relevant appendix.)

Date of the contested decision: (YEAR / MONTH / DAY)	File number:

If you have missed the six-month deadline for applying for a review of a decision of the Régie, please indicate the reasons justifying the delay.

Section 4 AUTHORIZATION AND DECLARATION

If you checked **box 1 of section 1** – You are authorizing the Régie de l'assurance maladie du Québec to contact any person or organization that has issued one of the documents provided so that the Régie may collect only the information needed to determine your eligibility, or that of the person you represent, for health insurance.

If you checked **box 2 of section 1** - You are authorizing the Régie de l'assurance maladie du Québec to contact, among others, the concerned employers, unions, professional orders or associations, or insurers so that the Régie may collect only the information needed to determine your eligibility, or that of the person you represent, for the Public Prescription Drug Insurance Plan.

If you checked boxes **3 to 12 of section 1** - You are authorizing the Régie de l'assurance maladie du Québec to request from the health professional or facility concerned all necessary information. If the information is not available free of charge, you agree to pay the fee required to obtain it.

I hereby authorize the Régie de l'assurance maladie du Québec to contact any person or organization mentioned above to collect only the information needed to process this application.	Signature of applicant X _____ Date YEAR MONTH DAY
I declare that all the information provided is complete and accurate.	Signature of applicant X _____ Telephone (daytime) Date YEAR MONTH DAY

Make sure that you have completed all required sections and signed the form before returning it.

INFORMATION ON THE REPRESENTATIVE

If you are submitting the application on behalf of someone else, please indicate in what capacity you are doing so:

Father: ☐ Mother: ☐ Other: ☐ Please specify and attach a power of attorney or mandate: _____

Last name of representative	First name of representative	
Address Number Street Apartment		Telephone (daytime)
Municipality		Postal code

Please send your application for review to the following address:

Direction de la révision
Régie de l'assurance maladie du Québec
C.P. 6600
Québec (Québec) G1K 7T3

For more detailed information, visit our website:

www.ramq.gouv.qc.ca

APPENDIX A

APPLICATION FOR REVIEW – HEALTH INSURANCE

(You checked **box 1 of section 1** of the form.)

The documents provided will serve to support your application for review, during the period at issue. You must ensure that all useful information, such as your last and first names, dates and signatures, clearly appears on your documents.

Examples of documents confirming that **you are present** or **domiciled** in Québec:

- Residential lease (copies of all pages);
- Deed of purchase of residential property (copies of all pages);
- Solemn affirmation or sworn statement by the owner or tenant confirming that you indeed reside at the address stated;
- Telephone, electricity or cable bill or statement;
- Municipal or school tax bill;
- Proof of property damage insurance;
- Bank or credit card statement;
- Statement of government benefits (family allowance, Old Age Security, etc.);
- Confirmation of school registration issued by an educational institution;
- Attestation by Québec employer, work contract, confirmation of hiring;
- Québec driver's licence, motor vehicle registration;
- Income tax return;
- Plane ticket, proof of travel insurance;
- Canadian and/or foreign passport (copies of all pages);
- Detailed statement of personal belongings completed for the Canadian Border Services Agency;
- Proof of end of health insurance coverage in another province;
- List of stays, past or upcoming, outside Québec (exact dates of departure from and return to Québec) and reason(s) for the stays.

If you spend time temporarily outside Québec as a **student**, **trainee**, **worker** or **cooperant**, please refer to our website to find out what documents you are required to supply.

For more detailed information or for information on other situations, visit our website:

www.ramq.gouv.qc.ca

APPENDIX B

APPLICATION FOR REVIEW - PUBLIC PRESCRIPTION DRUG INSURANCE

(You checked **box 2 of section 1** of the form.)

Make sure that you attach all documents required for the assessment of your application.

If one of the following situations applies to you, we recommend that you follow the steps given before submitting your application for review.

– If you wish to be reimbursed for the cost of prescription drugs purchased during the three months prior to the date you contacted the Régie to register for the public plan: contact your pharmacist or the Régie's Service à la clientèle;

– If you are contesting your contribution amount to the public plan in light of the Guaranteed Income Supplement (GIS) that you are or were receiving: contact Human Resources and Skills Development Canada (HRSDC);

– If you are contesting your contribution amount to the public plan in light of the last-resort financial assistance you are or were receiving: contact the Ministère du Travail, de l'Emploi et de la Solidarité sociale (MTESS).

Important

The *Act respecting prescription drug insurance* provides basic coverage that takes into consideration family circumstances: your own, those of your spouse and those of your children.

Definitions

Spouse

A person, of the opposite sex or same sex, with whom you:

- are married or have entered into a civil union;
- have been living for 12 months (any separation of under 90 days does not interrupt the 12-month period);
- are living (regardless of the length of time) and have had or have adopted a child together.

Child

- A person under age 18 over whom someone is exercising parental authority.
- A person under age 25, who lives with his/her father, mother or guardian, who is deemed to be a full-time student duly enrolled at an educational institution, and over whom a person exercises parental authority if the person is under 18.

Required information

You must indicate in section 3 of the form (or on a sheet signed by you and attached) the following information:

◆ The reasons for your application for review;

◆ The complete contact information for your current ***spouse*** and for the person who was your ***spouse*** during the period covered by the contested decision, if not the same person:

- Last and first names;
- Date of birth;
- Health Insurance Number ;
- Marital status and date of the event (married, de facto spouse or union, separated, divorced or widowed).

◆ The complete contact information for your ***children***, the ***children*** of your current ***spouse*** and the ***children*** of the person who was your ***spouse*** during the period covered by the contested decision, if not the same person:

- Last and first names;
- Date of birth;
- Health Insurance Number;
- Address (if different from yours).

◆ The period(s) you (and your ***spouse***, if applicable) were unemployed (e.g.: jobless, pursuing studies, staying at home, etc.) during the period covered by the contested decision.

Documents to attach to your application for review

Attestation by employer

For each job held by you, your **current *spouse*** and, where applicable, the person who was your ***spouse*** **during the period covered by the contested decision**, you must provide a signed letter from each employer containing the following information:

- Date of hiring and date of the last day of work, if applicable;
- Dates of sick leave, parental leave, unpaid leave or retirement leave, if applicable;
- Confirmation of whether or not the employer offers a group insurance plan providing basic prescription drug coverage. If the employer does offer such a plan, the document must specify:
  - The reason(s) why you do not qualify;

  or
  - The duration of the waiting period before being entitled to the plan;
  - The date when you became eligible and the date you joined the plan;
  - The type of coverage chosen (individual, single-parent or family);
  - The coverage end date, if applicable, and the reason the coverage ended.

Proof of membership in a professional association or order

For each professional association or order of which you, your **current *spouse*** and, where applicable, the person who was your ***spouse*** **during the period covered by the contested decision** are or were a member, you must provide a letter from the professional association or order containing the following information:

- The date membership in the professional association or order began and, if applicable, the date membership ended;
- Confirmation of whether or not one or the other of those associations or orders offers a group insurance plan providing basic prescription drug coverage. If such a plan is offered, the document must specify:
  - The reason(s) why you do not qualify;

  or
  - The duration of the waiting period before being entitled to the plan;
  - The date you became eligible and the date you joined the plan;
  - The type of coverage chosen (individual, single-parent or family);
  - The coverage end date, if applicable, and the reason the coverage ended.

Proof of studies

The required documents concern ***children*** age 18 to 25 who are full-time students and without a ***spouse***. For each ***child***, you must provide:

- ◆ One or more confirmations of registration for a full-time study program, which list(s) the number of units and/or number of course hours and/or confirming that the child is pursuing full-time studies, for the entire period covered by the contested decision;
- ◆ If the student holds one or more jobs, a letter from each employer containing the information listed in the above "Attestation by employer" section.

For more detailed information, visit our website:

www.ramq.gouv.qc.ca