Régie de l'assurance maladie Québec

REGISTRATION FOR THE OSTOMY APPLIANCES PROGRAM

PLEASE LEAVE THIS SPACE BLANK

1. Insured person's identity

HEALTH INSURANCE NUMBER
LETTERS | NUMBERS

LAST NAME

LAST NAME AT BIRTH
(IF DIFFERENT FROM THE ONE ALREADY REGISTERED)

FIRST NAME

DATE OF BIRTH
YEAR MONTH DAY

SEX
M F

HOME ADDRESS
NUMBER STREET APT.

LOCALITY POSTAL CODE

2. Type of operation

☐ permanent colostomy ☐ permanent ileostomy ☐ permanent urostomy

Date of operation
YEAR MONTH DAY | YEAR MONTH DAY | YEAR MONTH DAY

Date of discharge from hospital
YEAR MONTH DAY | YEAR MONTH DAY | YEAR MONTH DAY

ATTACH THE ORIGINAL MEDICAL CERTIFICATE
OR

PHYSICIAN'S SIGNATURE

DATE
YEAR MONTH DAY

HEALTH PROFESSIONAL NUMBER

3. Autorisation to be given by the holder of a claim slip (*carnet de réclamation*)

I hereby authorize the Régie de l'assurance maladie du Québec to contact the Ministère du Travail, de l'Emploi et de la Solidarité sociale for the purpose of gathering only that information necessary to process my application.

SEND YOUR ORIGINAL INVOICES TO THE RÉGIE TO RECEIVE THE SUPPLEMENT, IF APPLICABLE.

X _____
SIGNATURE

DATE
YEAR MONTH DAY

4. Insured person's signature

I wish to register for the Ostomy Appliances Program in order to receive financial assistance.

I hereby declare that the information provided is accurate and complete.

X _____
SIGNATURE

DATE
YEAR MONTH DAY

HOME TELEPHONE
AREA CODE

WORK TELEPHONE
AREA CODE EXT.