Régie de l'assurance maladie Québec

Application for Registration
Ostomy Appliances Program

PLEASE LEAVE THIS SPACE BLANK

SECTON 1: TO BE COMPLETED BY THE INSURED PERSON

1. Identity of the insured person

Last name	Last name at birth (if different from the one already registered)		
First name	Date of birth (Year / Month / Day)	Health Insurance Number	Sex ☐ M ☐ F
Home address Number	Street		Apartment
Municipality			Postal code

2. Obligation of the insured person

Attach a medical prescription containing the following:

- Your first and last names
- Your date of birth or Health Insurance Number
- The date and type of surgery (colostomy, ileostomy or urostomy)
- Confirmation of whether the ostomy is permanent or temporary
- The first and last names, (block letters) and license number of the physician
- The date of issuance of the prescription
- The physician's signature

Or

Have the physician complete the reverse side of this form.

3. Signature of the insured person

I wish to register for the Ostomy Appliances Program.
I hereby declare that the information provided is accurate and complete.

X _____ (Signature) Year / Month / Day (Date)

Home telephone Area code	
Work telephone Area code	Ext.

Send the form and required documents to the following address:

Régie de l'assurance maladie du Québec
Ostomy Appliances Program – DGPHQATF
Case postale 6600
Québec (Québec) G1K 7T3

We recommend that you keep copies of the documents that you send us.
We may require additional documents necessary for the assessment of your application.

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN (OPTIONAL)

1. Identification of the facility or clinic

Name of the facility or clinic

Telephone
Area code

Address of the facility or clinic

Number

Street

Municipality

Postal code

2. Identity of the insured person

Last name

First name

Date of birth
Year Month Day

OR

Health Insurance Number

3. Type of operation

☐ **Colostomy**
Operation date
Year Month Day

☐ **Ileostomy**
Operation date
Year Month Day

☐ **Urostomy**
Operation date
Year Month Day

Type

☐ **Permanent**

☐ **Temporary**

4. Identity and signature of the physician

Name of the physician in block letters

X

Signature of the physician

Year Month Day
Date

License number