Régie de l'assurance maladie Québec

Claim for Payment

Outpatient services rendered to residents of Québec (to be used by hospitals excluded from interprovincial billing)

LEAVE THIS SPACE BLANK

External control number

1- Facility

FACILITY CODE | NAME OF FACILITY

ADDRESS (number, street, locality) | PROVINCE | POSTAL CODE

2- Details of claim

For each claim (A, B, C):

HEALTH INSURANCE NUMBER | INSURED PERSON'S LAST AND FIRST NAME ON CARD (IN BLOCK LETTERS) | SERVICE CODE | RATE FOR SERVICE

EXPIRY DATE OF CARD YEAR MONTH | NEWBORN ☐ | DATE OF BIRTH YEAR MONTH DAY | SEX M/F | SERVICE DATE YEAR MONTH DAY

DIAGNOSTIC CODE

INTERVENTION CODE

INTERVENTION ATTRIBUTES STATUS LOCATION EXTENT STATUS LOCATION EXTENT STATUS LOCATION EXTENT

ADDITIONAL INFORMATION, WHERE APPLICABLE

3- Attestation by facility

The person signing this form on behalf of the facility attests that the above information is accurate.

Last name and first name of authorized person (IN BLOCK LETTERS)

Signature of authorized person | YEAR MONTH DAY

White copy: **RAMQ** – Yellow copy: **Facility**