	LEAVE THIS				LEAVE THIS SPACE BLANK —			
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)		External control number				
	Facility							
FAC	CILITY CODE NAME OF	FACILITY						
AD	ADDRESS (number, street, locality)			PROVINCE	POSTAL	AL CODE		
2-	Details of claim							
	HEALTH INSURANCE NUMBER INSURED PERSON'S LAST AND FIRST NAME ON CARD (IN BLOCK LETTERS)				SERVICE	RATE		
						CODE	FOR SERVICE	
	EXPIRY DATE OF CARD YEAR MONTH	NEWBORN	DATE OF BIRTH YEAR	ONTH DAY M/F SERVICE I	DATE EAR MONTH DAY			
A	DIAGNOSTIC CODE					-		
	DIAGNOSTIC CODE							
	INTERVENTION CODE							
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	ADDITIONAL INFORMATION, WHERE	APPLICABLE						
\vdash	HEALTH INSURANCE NUMBER		INSURED PERSON'S LAST AND FIRST NAM	ME ON CARD (IN BLOCK LETTERS	S)			
		1						
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	ADDITIONAL INFORMATION, WHERE	APPLICABLE						
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	HEALTH INSURANCE NUMBER	I	INSURED PERSON'S LAST AND FIRST NAM	VIE ON CAND (IN BLOCK LETTERS	5)			
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	YEAR MONTH NEWBORN YEAR MONTH DAY M/F YEAR MONTH DAY							
С	DIAGNOSTIC CODE					1		
	INTERVENTION CODE				1 1 1 1 1			
	INTERVENTION ATTRIBUTES							
	STATUS LOCATION	EXTENT	STATUS LOCATION EXTENT	STATUS LO	CATION EXTENT			
	ADDITIONAL INFORMATION, WHERE	APPLICABLE				-	}	

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)

YEAR MONTH DAY