Régie de l'assurance maladie Québec

Claim for Payment

Inpatient 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- Patient

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

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

ADDRESS (number, street, locality) | POSTAL CODE

3- Details of claim

ADMISSION DATE (YEAR / MONTH / DAY) | DISCHARGE DATE (YEAR / MONTH / DAY) | TYPE OF STAY | ACCIDENT ☐ CODE | DEATH ☐

DIAGNOSTIC CODE

INTERVENTION CODE

INTERVENTION ATTRIBUTES (STATUS / LOCATION / EXTENT)

EMERGENCY (YEAR / MONTH / DAY) | LOCALITY, PROVINCE | AUTHORIZATION NUMBER

DESCRIPTION OF EMERGENCY | REGISTER CODE

DATE OF OPERATION OR OF BEGINNING OF BILLING (YEAR / MONTH / DAY)	DATE OF END OF BILLING (YEAR / MONTH / DAY)	SERVICE CODE	DAILY RATE	NUMBER OF DAYS	AMOUNT BILLED
			TOTAL		

4- Additional information

5- 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 | DATE (YEAR / MONTH / DAY)

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