Régie de
l'assurance maladie
Québec

Confirmation and Authorization by the Insured Person

1 - Insured person

Last and first names

Address
Number | Street | Apartment

Municipality | Province | Postal code

Health Insurance Number | Date of birth (YEAR MONTH DAY) | Sex M ☐ F ☐ | Home phone number (AREA CODE)

I confirm that I received the following good(s) or service(s):

Date of service	Description of the goods or service(s)	Signature of the insured person (or his or her representative)
YEAR MONTH DAY		

I also authorize the Régie de l'assurance maladie du Québec to issue payment to the following authorized provider:

2 - Provider

Name of provider

Provider's location or place of business | Phone (AREA CODE)

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