Régie de l'assurance maladie Québec

OUT-OF-PROVINCE CLAIM FOR PHYSICIAN SERVICES

SPACE RESERVED FOR ADMINISTRATIVE PURPOSES

A Section to be completed by Patient or Representative *(please type or print clearly)*

PATIENT'S LAST NAME ON HEALTH CARD | FIRST NAME | MEDICARE NUMBER

PERMANENT MAILING ADDRESS | CARD EXPIRY DATE

MUNICIPALITY | PROVINCE/TERRITORY | POSTAL CODE

BIRTHDATE YEAR MONTH DAY | SEX ☐ M ☐ F | NAME OF PARENT, TUTOR OR REPRESENTATIVE | RELATION TO THE INSURED PERSON

DATE OF DEPARTURE FROM HOME PROVINCE/TERRITORY YEAR MONTH DAY | DATE OF RETURN TO HOME PROVINCE/TERRITORY YEAR MONTH DAY | PLACE WHERE TREATED (PROVINCE OR TERRITORY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | IF YES, INDICATE THE MOVE DATE YEAR MONTH DAY | GIVE REASON FOR ABSENCE FROM HOME ☐ VACATION ☐ STUDY ☐ WORK ☐ OTHER: (specify) _____

B Declaration of Patient or Representative

I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the *Canada Evidence Act*, that the information given above is correct and that I am covered under the medical care plan of the province/territory of _____.

SIGNATURE OF PATIENT (if other than patient, state relationship to patient) X _____ | DATE YEAR MONTH DAY | TELEPHONE NO. (Work) AREA CODE | TELEPHONE NO. (Home) AREA CODE

C Section to be completed by Health Professional *(please type or print clearly)*

HEALTH PROFESSIONAL'S LAST NAME | FIRST NAME

NAME OF BUSINESS (IF APPLICABLE)

☐ SPECIALIST SPECIALTY _____ ☐ ASSISTANT

☐ GENERAL PRACTITIONER ☐ DENTIST ☐ MAXILLOFACIAL SURGEON

☐ OPTOMETRIST ☐ OTHER _____

DURATION OF TREATMENT HRS MINS

ADDRESS NUMBER STREET MUNICIPALITY | NAME OF REFERRING PHYSICIAN

PROVINCE OR TERRITORY | POSTAL CODE | TELEPHONE NUMBER AREA CODE | SPECIALITY

☐ PAYMENT TO HEALTH PROFESSIONAL ☐ REIMBURSEMENT TO PATIENT ☐ PAYMENT TO BUSINESS

NAME AND ADDRESS OF HOSPITAL (IF APPLICABLE) | ADMISSION DATE YEAR MONTH DAY | DISCHARGE DATE YEAR MONTH DAY

D Description of services rendered

DESCRIPTION OF SERVICES	FEE CODE	FEE	DATE OF SERVICE YEAR MONTH DAY	TIME HEURES MINUTES	Place where the services were rendered: OFFICE	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	EMERGENCY ROOM	HOME
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

HOW WAS THE SERVICE RENDERED?

☐ BY TELEPHONE ☐ BY VIDEOCONFERENCE ☐ IN PERSON

DIAGNOSIS AND OTHER REMARKS | CLAIM INVOLVES: ☐ WORK ACCIDENT ☐ AUTOMOBILE ACCIDENT | DATE OF ACCIDENT YEAR MONTH DAY

I accept the patient's plan payment as payment in full.

HEALTH PROFESSIONAL'S SIGNATURE X _____ | PERMIT NUMBER | DATE YEAR MONTH DAY | LANGUAGE OF CORRESPONDENCE ☐ FRENCH ☐ ENGLISH