Régie de
l'assurance maladie
Québec

FOR INTERNAL USE

☐ Request for additional information

Application for Reimbursement of Fee Billed by a Health Professional

The form is to be used to submit a request for reimbursement for cost related to a medical, dental, optometric or pharmaceutical service rendered in Québec. It is also to be used to file an application for review.

☐ **Request for reimbursement** **or** ☐ **Application for review** ▶ Date of the initial decision Year Month Day

1. Information on the insured person who received the service(s)

Last name at birth	Health Insurance Number	
First name at birth	Date of birth Year Month Day	Sex ☐ M ☐ F

Home address (to notify us of a change of address, please read the instructions on the reverse side)

Number	Street	Apartment
Municipality	Province	Postal code

2. Information on the health professional who provided the service(s)

Last name	First name	Health professional number (if known)

Category of professional

☐ Dentist ☐ Optometrist ☐ Pharmacist ☐ Physician, specialty:

☐ Other:

3. Facility where the services were received

Name of the facility where services were rendered

Address of the facility

Number	Street	
Municipality	Province	Postal code

4. Information on the service(s) received

Date	Description of the services received	Health Insurance Card or claim slip (*carnet de réclamation*) presented	Amount paid
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	
Year Month Day		☐ Yes ☐ No	

Please attach photocopies of your invoices or receipts as proof that you have paid for the service(s). No original document will be returned.

Total ▶

4388 *235 21/05*

5. Power of Attorney (where applicable)

I, the undersigned, ____,
Name of the insured person who received the service(s) (in block letters)

authorize ____
Name of mandatary (in block letters)

to represent me in my dealings with the Régie de l'assurance maladie du Québec (RAMQ) in order follow up on this request or reimbursement. I therefore allow RAMQ to share with him or her the confidential information contained in my file to the extent that it relates to this request.

This power of attorney takes effect on the date that this request for reimbursement is signed and remains valid for an indefinite period or until ________________________, unless the undersigned revokes it by writing to RAMQ.

Representative's last name at birth	Representative's first name at birth

Representative's domicile address

Number	Street	Apartment

Municipality	Province	Postal code

X ______________________ ______________________ ______________________
Signature of the insured person who received the services — Location — Date

6. Comments

7. Signature of the insured person or his or her representative

I certify that the information provided herein is accurate and I request the reimbursement of the services listed in section 4.

X ______________________ ______________________
Signature of the insured person or his or her representative — Date

To contact RAMQ

Website
www.ramq.gouv.qc.ca

Telephone
Québec: 418 646-4636
Montréal: 514 864-3411
Elsewhere in Québec: 1 800 561-9749

Mail
Régie de l'assurance maladie du Québec
C. P. 6600, succ. Terminus
Québec (Québec) G1K 7T3

Instructions

Complete this form if you wish to submit a request for reimbursement where you believe that you were wrongfully billed for any of following services:

- medical
- dental
- optometric
- pharmaceutical (other than prescription drugs)

Complete this form also if you wish to file an application for review where you disagree with the RAMQ's decision following your request for reimbursement.

This form may also be used by RAMQ to request additional information to complete your request for reimbursement.

This form is for **a single health professional and one location where services were received.** However, it can be used for several services received on different dates.

N.B.: You must use another form in the following cases:

- If you are requesting the reimbursement of charges billed by a hospital, **please contact the facility concerned**.
- If you are requesting the reimbursement of charges related to insured services received outside Québec, please complete the form entitled *Application for Reimbursement* (1896), available on our website.
- If you are requesting the reimbursement of prescription drugs purchased at a pharmacy, please ask the pharmacist for the form entitled *Demande de remboursement à la personne assurée* (3621).
- For medical services: If you are requesting the reimbursement of charges that you had to pay **because you did not present your Health Insurance Card or it was expired**, please ask the physician for the form entitled *Demande de remboursement (carte expirée ou non présentée)* (4314).
- For dental services: If you are requesting the reimbursement of charges that you had to pay **because you did not present your claim slip (*carnet de réclamation*) or your Health Insurance Card, or one of these documents was expired**, please ask the dentist for the form entitled *Demande de remboursement (carte expirée ou non présentée)* (4314).
- For optometric services: If you are requesting the reimbursement of charges that you had to pay **because you did not present your Health Insurance Card or it was expired**, please ask the optometrist for the form entitled *Demande de remboursement (carte expirée ou non présentée)* (4314).

Section 1 – Information on the insured person who received the service(s)

This form cannot be used to make a change of address. Before you complete it, ensure that your change of address has been made at the Service québécois de changement d'adresse at **www.adresse.gouv.qc.ca**; otherwise, your cheque could be sent to your former address.

Section 2 – Information on the health professional who provided the service(s)

If you know the number of the health professional who provided you with the service(s), please enter the number in the space provided.

If the health professional in question is a physician, indicate his or her specialty in the space provided (e.g. family doctor, surgeon).

Section 3 – Facility where the services were received

Please indicate the name of the facility (e.g. medical clinic) where the services that you received were rendered.

Section 4 – Information on the service(s) received

For payments made by you since December 7, 2015, you have 5 years from the date on which you made the payment to submit the corresponding request for reimbursement to RAMQ.

For each service, you must send RAMQ a photocopy of the invoice or receipt issued by the health professional or health facility, as proof that you have paid for the service.

If the space provided in this section is insufficient, please attach a sheet detailing the other services for which you are seeking to be reimbursed. These services must have been rendered by the health professional described in section 2 at the facility identified in section 3.

Section 5 – Power of Attorney (where applicable)

Complete this section if you mandate another person to represent you in your dealings with RAMQ for this request for reimbursement. You may at any time submit a written request to RAMQ to revoke this power of attorney.

This section does not need to be completed by the parent of a minor child if it is the latter who received the care described in section 4.

If you are making the request for a deceased person, first make certain that you are registered with RAMQ as the liquidator of the person's succession.

Section 6 – Comments

Use this section for any additional comments you may have. If the space provided is insufficient, attach a letter with your comments.

If you are using this form to apply for a review, you can use this space for any additional information that you deem relevant.

Section 7 – Signature of the insured person or his or her representative

All the fields of this section must be completed.