Régie de
l'assurance maladie
Québec

Frequently asked questions about costs billed

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Note that this FAQ has no legal value for adjudicating legal issues. It is important to refer to the official text of the laws, where applicable.

REQUESTS FOR REIMBURSEMENT

Is it true that not all health professionals offer covered services?

Yes. Only participating health professionals offer covered services.

For more information on the covered services for which you are entitled to a reimbursement, please consult the following pages:

- Medical services
- Dental services
- Optometric services
- Pharmaceutical services

I consulted a health professional and was billed. Am I automatically entitled to a reimbursement?

No. Only **participating health care professionals** are subject to the *Health Insurance Act* (HIA). The latter offer covered services and are remunerated by the RAMQ.

Non-participating health care professionals can bill you the amount of their choice for a given service rendered. They are not governed by the RAMQ and are not subject to the HIA. Consultations with these professionals are therefore at your expense.

For further information, consult the page Professionals offering covered services.

Who are the professionals whose fees are not reimbursable?

We do not reimburse the fees billed by the following professionals when they are self-employed:

- Acupuncturists
- Audiologists
- Chiropractors
- Nurses
- Kinesiologists
- Naturopaths
- Naturotherapists
- Dieticians
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Massage therapists

* Certain exceptions apply.

For further information, consult the page Professionals offering covered services.

I feel that the fees billed by a physician are too high or I question the quality of the services received. What can I do?

You can file a complaint with the Collège des médecins du Québec.

By mail:	By telephone:
Collège des médecins du Québec 1250, boulevard René-Lévesque Ouest, Bureau 3500 Montréal (Québec) H3B 0G2	514 993-4441 (Montréal) 1 888 633-3246 (toll-free)

What conditions must be fulfilled in order to be eligible for a reimbursement?

You can obtain a reimbursement only if the costs billed to you are covered by health insurance or in connection with a covered service. However, you must be insured by the health insurance of Québec on the date of the service and have paid the costs required of you.

To know whether the service for which you wish to request the reimbursement is covered, please consult the following pages:

- Medical services
- Dental services
- Optometric services
- Pharmaceutical services

The page Other services contains information on other financial assistance programs (hearing aids, appliances for ostomates, etc.).

I received medical care from a physician not participating in the public plan. May I obtain a reimbursement?

Non-participating health professionals practise their profession outside the scope of the Public Health Insurance Plan and are not remunerated in accordance with the tariffs provided for in the agreement. They themselves determine their tariffs, which are assumed entirely by their patients. We thus cannot reimburse you the fees billed by a health professional not participating in the public plan.

How can I apply for a reimbursement?

In order to be reimbursed for costs related to a covered service (accessory costs), you need to send us the form Application for Reimbursement (accessory costs), duly completed, accompanied by the following documents:

- a copy of detailed invoices issued by the medical clinic or the health professional
- proofs of payment showing that the fees were paid to the clinic or to the professional.

Send your application for reimbursement to the following address:

Régie de l’assurance maladie du Québec
Case postale 6600, succ. Terminus
Québec (Québec) G1K 7T3

Remember to indicate your Health Insurance Number on all documents so that we may associate your application with your file.

What is the deadline for submitting my documents to obtain the reimbursement of costs that were billed to me (accessory fees)?

You have **5 years** from the date on which you paid**.** To be eligible for a reimbursement, you have to present proofs of payment of the costs billed dated **less than 5 years ago**. Once the five-year deadline has passed, we will no longer be able to reimburse you.

Please note that services paid **prior to December 2015** cannot be reimbursed to you, because of the time limits previously set out in the Act.

What is the processing time for an application for reimbursement of costs wrongfully billed by a health professional?

Processing time is **60 working days**, after we receive the necessary documents. We will notify you in writing if we require more than 60 working days for reasons beyond our control.

I did not present my valid Health Insurance Card at the time of a consultation with a participating health professional. How long do I have for submitting my documents to obtain a reimbursement of the professional fee (salary) billed to me?

You have **one year after obtaining** the covered service to apply for a reimbursement of professional fees billed to you.

May I generate a request for reimbursement for a friend or family member?

To act on behalf of a person of full age (18 years of age or older) or a child for whom you are not the legal guardian, you would need to **provide** us **with a power of attorney**, signed by the person whom you are representing.

If the request for reimbursement is in relation to a covered service (accessory fees), you need only complete section 5 of the form Application for Reimbursement (accessory costs) and mail it to us at the following address:

Régie de l’assurance maladie du Québec
Case postale 6600, succ. Terminus
Québec (Québec) G1K 7T3

If the application is not accompanied by a power of attorney, we will communicate only with the person concerned.

COVERED SERVICES AND NON-COVERED SERVICES

Which services are covered by health insurance?

We do not cover all medical services. Indeed, some may be billed to you: the services not covered by the health plan and those offered by professionals who practise their profession outside the scope of the public health care plan (non-participating).

The services covered by Québec health insurance are services that are medically required. They must be rendered by a participating professional.

For more information on the services covered by the public plan, consult the following pages:

- Medical services
- Dental services
- Optometric services
- Pharmaceutical services

Which services are not covered by health insurance?

Non-covered services generally correspond to procedures performed by a professional who does not participate in the public plan, to interventions that are not medically required or to interventions addressed by the Regulation respecting the application of the Health Insurance Act. Services that are not associated with preventing, healing or curing illnesses or diseases are not covered. You must therefore assume their cost.

It is important to point out that some services are not covered in a medical clinic whereas they are when rendered in a hospital. Do not hesitate to check whether fees will be billed to you before receiving a service.

Does RAMQ reimburse the fees billed by health facilities (hospital centres, CLSCs, residential and long-term care centres, rehabilitation centres, etc.)?

No. We do not reimburse fees billed by health facilities. To make a claim or file a complaint concerning a health facility, you will need to contact the service quality and complaint commissioner of the facility in question.

However, if the physician of a **health facility** bills you for his or her **fees** (his or her salary), complete the form Demande de remboursement (carte expirée ou non présentée) and mail it to us at the following address:

Régie de l'assurance maladie du Québec
Case postale 6600, succ. Terminus
Québec (Québec) G1K 7T3

Is transport by ambulance a covered service?

No. We do not cover the cost of transport by ambulance. For more information on the cost of ambulance transport as well as the government exceptional assistance measures, please consult the website of Services Québec.

May I request that a non-covered service be covered, exceptionally?

We are unable to dedicate sums to persons who have paid for non-covered services and therefore cannot reimburse you the costs associated with the service.

OPHTHALMOLOGY

Which ophthalmological services are covered?

The following fees **cannot be billed to you** by a participating physician, if they are related to a covered service:

- Eye drops of any kind (mydriatic, anesthetic and other)
- Optical biometry
- Retinophotography
- Cataract extraction (all techniques, including the use of laser)
- Optical coherence tomography (OCT) conducted in a clinic to treat, by an intravitreal injection, one of the following pathologies:
  - age-related macular degeneration
  - macular edema caused by vein occlusion
  - diabetic macular edema
  - retinopathy of prematurity
  - malignant myopia
  - neovascular glaucoma
  - neovascular diabetic retinopathy

Soft contact lenses (single-piece, foldable, monofocal aspheric intraocular lenses), placed on the cornea during laser surgery are covered, thus, free-of-charge. Toric contact lenses or speciality lenses are not covered. If you wish to obtain lenses other than those covered, you will need to pay the difference between the cost of your lenses and that of the lenses that are covered.

Which ophthalmological services are not covered?

The following costs may be billed to you, as they are related to a non-covered service:

- Corrective eye surgery, aimed at doing away with wearing eyeglasses or contact lenses (e.g. refractive laser surgery). Exceptions are made for persons who fulfill the following two conditions:
  - documented failure regarding the wearing of eyeglasses or corneal lenses
  - anisometropia of more than 5 diopters or astigmatism of more than 3 diopters
- Optical coherence tomography (OCT) performed in a clinic and **that is not related to** an intravitreal injection for one of the following pathologies:
  - age-related macular degeneration
  - macular edema caused by vein occlusion
  - diabetic macular edema
  - retinopathy of prematurity
  - malignant myopia
  - neovascular glaucoma
  - neovascular diabetic retinopathy
- Echography of the eye performed in a clinic by a physician other than a radiologist participating in the public plan

- Ultrasound pachymetry or biometry of the eye performed in a clinic

OPTOMETRY

Most optometric services are not covered by health insurance.

Who is able to obtain covered optometric services?

You can benefit from covered optometric services if you are insured under the health insurance plan and meet certain criteria. For more information, consult the page Optometric services.

Are there any optometric services that are covered for all insured persons?

Yes. Consult the page Optometric services for more information.

Can an optometrist bill for eye drops?

The administration of eye drops during a covered service cannot be billed by an optometrist participating in the public plan, whether the service is rendered in a medical clinic or hospital centre. However, if you wish to purchase eye drops for use at home, you have to pay for them.

Is the purchase of eyeglasses or contact lenses covered by health insurance?

No. Neither the purchase of prescription eyeglasses nor contact lenses is covered by the public plan. Consequently, we do not reimburse the costs billed for this service.

I feel that the costs billed by my optometrist are too high or I question the quality of the services received. What should I do?

You may file a complaint with the Ordre des optométristes du Québec.

By mail:
Bureau du syndic
Ordre des optométristes du Québec
1265, rue Berri, bureau 505
Montréal (Québec) H2L 4X4

By telephone:
514 499-0524, ext. 230 (Montréal)
1 888 499-0524 (toll-free)

DENTAL SERVICES

Who is covered for dental services?

Very few dental services are covered by the public plan. To be eligible for these services, the person must be under 10 years of age or be a recipient of last-resort financial assistance and be holding a valid claim slip (*carnet de réclamation*) for at least the past 12 months.

For information on the services covered for this clientele, consult the page Dental services.

Can financial assistance be obtained for orthodontic treatments?

No. Orthodontic services are not covered, regardless of the reason for which the treatment is required. The same rule applies to everyone. We therefore cannot reimburse the costs that you may be billed for these services.

I need dental services covered by the claim slip (*carnet de réclamation*), but am currently in the waiting period. What can I do?

You are not eligible for covered services during the waiting period. All services received before your eligibility date as covered dental services are at your expense. When you become eligible, we will cover the dental costs to which you are entitled. Some exceptions apply.

I need to change my dental prostheses before the date on which renewal is allowed. Is that possible?

Yes. If you have had a valid claim slip (*carnet de réclamation*) for at least 24 consecutive months, your dental prosthesis (full or partial) is covered for a period of 8 years.

If you **lose or damage your prosthesis** before the end of the 8-year period, you may be eligible for financial assistance. Consult your local employment centre to learn how to obtain the prior authorization needed.

Metallic (vitallium) prostheses and those placed on implants are not covered.

I believe that the costs billed by my dentist are too high or I question the quality of the services received. What can I do?

You can file a complaint with the Ordre des dentistes du Québec.

By mail:
Bureau du syndic
Ordre des dentistes du Québec
800, boulevard René-Lévesque Ouest, bureau 1640
Montréal (Québec) H3B 1X9

By telephone:
514 875-8511, ext. 2270 (Montréal)
1 800 361-4887 (toll-free)

ADMINISTRATIVE FEES

As a general rule, you cannot be billed for an administrative procedure related to a covered service rendered by a physician participating in the public plan. By contrast, an administrative procedure conducted at your request may be billed to you, whether related to a covered or non-covered service.

Can I be billed for:

having a file opened?

No. Opening a file at a clinic where physicians participating in the public plan are practicing their profession cannot be billed to you, since the procedure is related to a covered service.

missing an appointment?

Yes. A physician participating in the public plan is entitled to bill you a fee for a missed appointment. However, the clinic's billing policy must be displayed in the physician's clinic, along with the associated fees.

renewing a prescription?

The renewal of a prescription cannot be billed to you when you have an appointment with a physician participating in the public plan if the physician renders covered medical services at the same time. This principle also applies to a new prescription or the replacement of a lost prescription slip.

However, you can be billed fees for renewing a prescription if you do not meet with the physician for a consultation or if this service is the only reason for your consultation.

having a form completed?

Yes. Having a physician complete a medical certificate (form) is not a covered service*,* as a rule. You can thus be billed for this service and you will not be able to be reimbursed for the fee.

Exceptions – Forms that are covered:

The completion of certain medical certificates (forms) and examinations associated with them, where applicable, are covered in the following cases:

- Proof of death
- Medico-legal examination of a sexual assault victim
- Examination required under the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*
- Examination required under the *Public Curator Act*
- Examination required under the *Individual and Family Assistance Act* (except the new examination required by the Minister of Income Security)
- Examination required under the *Youth Protection Act*

Moreover, some forms are required in the framework of a request for authorization for submission to RAMQ. In such a case, you cannot be billed for having the following forms completed:

- Demande d’autorisation de paiement – Médicament d’exception (payment authorization request - exceptional medication)
- Demande d’autorisation de paiement – Mesure du patient d’exception (payment authorization request - exception patient program)
- Demande d’autorisation en plastie (plasty authorization request)

having a report, recommendation or attestation prepared?

The drafting of a report, recommendation (e.g. doctor's note) or an attestation cannot be billed to you when it is related to a covered service rendered by a participating physician.

However, the drafting of a report made for you or a third party (e.g. an insurer, employer, health professional not participating in the public plan or the Société de l’assurance automobile du Québec) can be billed to you.

a copy of a medical record, copying of images on a digital support (e.g. CD, DVD), the drafting of a summary, photocopies, faxes or the transfer of a record?

The copying of a medical record, including images, the drafting of a summary, photocopying, faxes and the transfer of a record cannot be billed to you when related to a covered service rendered by a physician participating in the public plan.

However, if you request these services for a third party (e.g. an insurer, employer, health professional not participating in the public plan, the Société de l’assurance automobile du Québec) or for a reason not related to a covered service, you may be billed fees.

the transport of a sample?

Since January 26, 2017, fees may be billed to you for the transportation of a sample for analysis purposes. The amounts billed may not exceed:

- $15 for the transportation of a sample that includes blood
- $5 for the transportation of any other sample (e.g. culture for a bacteriological examination)

You may be billed these fees only once per sample collection session, even if there is more than one sample to be transported.

MEDICATIONS AND SUPPLIES

Medications, anesthetics, supplies and the equipment used during a covered service cannot be billed to you by a physician participating in the public plan or by a professional working for a clinic where a participating physician practises his or her profession.

Can I be billed for:

the supplies or medications used during a covered service?

The medications needed for treatment are covered only when they are used during a covered service, since they are included in the service. Medications used during a non-covered service, that is, a service that is not medically required, may be billed to you.

As regards supplies, equipment or products used by a physician participating in the public plan in the context of a covered service, they cannot be billed to you since they are included in the service. Some exceptions apply.

A physician participating in the public plan who plans to render a service (e.g. an injection) to you is entitled to ask you to obtain from a pharmacy the medications necessary for the injection. However, the physician cannot ask you to procure the products needed for the service (e.g. injection kit), since it is included in the service.

liquid nitrogen?

Liquid nitrogen cannot be billed to you by a physician participating in the public plan when used in the context of a covered service. However, liquid nitrogen may be billed to you if the service rendered is not covered, that is, not medically required.

infiltration and injection products?

Infiltration and injection products used during a covered service cannot be billed to you by a physician participating in the public plan or by the clinic where the physician is practising. However, the physician may ask you to procure the injection or infiltration product at your expense at a pharmacy.

viscosupplements?

Viscosupplements used during a covered service cannot be billed to you by a physician participating in the public plan or by the clinic where the physician is practising. However, the physician may ask you to procure the viscosupplement at your expense from a third party (e.g. pharmacy).

intrauterine devices?

Hormonal intrauterine devices (IUDs) cannot be billed to you by a physician participating in the public plan. However, the physician may ask you to procure the hormonal IUD at your expense at a pharmacy.

Copper intrauterine devices are supplied by the health care network when their placement is made immediately after a voluntary interruption of pregnancy (VIP), carried out in certain private clinics and certain women's health centres. If the copper intrauterine device is not related to a VIP, you must procure it at your expense at a pharmacy.

plaster casts?

A physician participating in the public plan cannot bill you for a plaster cast (plaster of Paris). However, if you wish to have a premium cast (e.g. a fibreglass cast), you will need to pay the difference between its cost and that of a basic plaster cast.

splints?

A physician participating in the public plan cannot bill you for a basic splint. However, if you wish to have a premium splint, you will need to pay the difference between its cost and that of a basic splint.

taping?

No. A physician participating in the public plan cannot bill you for the bandage used for immobilization (taping).

DIAGNOSTIC TESTS

Can I be billed for:

having simple tests made (strep test, screening tests for sexually transmitted or blood-borne infections, urine test strip, pregnancy test, blood glucose test, etc.)?

You cannot be billed for simple tests conducted by a participating physician or by a non-autonomous professional (e.g. nurse employed at a clinic where participating physicians practice their profession). In these circumstances, the costs are related to a covered service.

However, this service can be billed to you by a laboratory if the test analysis does not require the intervention of a participating physician.

undergoing an electrocardiogram?

The administration of an electrocardiogram cannot be billed to you by a participating physician or by a non-autonomous professional, such as a nurse employed at a clinic where participating physicians practise their profession.

However, the administration of a resting electrocardiogram can be billed to you by a laboratory if the findings are interpreted by the referring professional.

undergoing tests for sleep apnea?

Undergoing tests for sleep apnea cannot be billed to you by a laboratory, a participating physician or by a non-autonomous professional (e.g. nurse employed at a clinic where participating physicians practise their profession).

However, you can be billed by a laboratory for making a recording for a sleep apnea test if the result sent by the laboratory does not include a physician's interpretation of the results.

an ultrasound?

The costs of an echography (or ultrasound) cannot be billed to you when it is performed:

- in a health care facility (CLSC, long-term care centre, hospital centre, etc.)
  OR
- by a **radiologist participating** in the public plan.

Note that an echography carried out under the Program for free universal access to voluntary medical termination of pregnancy (abortion pill) cannot be billed to you when performed by a participating physician.

x-rays?

Radiology services rendered by a participating physician cannot be billed to you, unless they are carried out:

- in view of rendering a non-covered service OR
- by a person other than a physician, specialised nurse practitioner, dentist or physiotherapist

mammograms?

A **diagnostic mammogram** is a covered service and cannot be billed to you when carried out by a participating physician.

A **screening mammogram** cannot be billed by a participating physician when:

- it is conducted at one of the screening centres designated by the Québec Breast Cancer Screening Program
- it is conducted on a woman age 35 or older
- it has been 1 year since one was last conducted

a magnetic resonance imaging (MRI) examination?

A magnetic resonance imaging (MRI) examination is not a service covered by health insurance. You can thus be billed for this service when rendered at a clinic.

a computerized axial tomography, also called a CAT scan?

A computerized axial tomography, also called a computer-assisted axial tomography (CAT scan), is not a service covered by health insurance. You can thus be billed for this service when rendered at a clinic.

a vasectomy?

A vasectomy is a service covered by health insurance. Consequently, you cannot be billed for this service.