Régie de l'assurance maladie Québec

APPLICATION FOR REIMBURSEMENT

Before completing this form, read the reverse side and refer to the information on our website at **www.ramq.gouv.qc.ca**. Click on **Temporary stays outside Québec** under Citizens.

FOR OFFICE USE

CHECK THE APPROPRIATE BOX Healthcare services received: ☐ in Canada ☐ outside Canada

APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER (LETTERS / NUMBERS)

LAST NAME

LAST NAME AT BIRTH (IF DIFFERENT FROM THE NAME ON THE HEALTH INSURANCE CARD)

FIRST NAME

DATE OF BIRTH (YEAR / MONTH / DAY)

SEX ☐ M ☐ F

HOME ADDRESS (see over)

NO. / STREET / APT. / MUNICIPALITY

PROVINCE / POSTAL CODE / PHONE NUMBER AT HOME AREA CODE / PHONE NUMBER AT WORK AREA CODE

PERIODS OF TIME SPENT OUTSIDE QUÉBEC

Period during which you received healthcare services

Date of departure from Québec (Year / Month / Day)

Date of return to Québec ☐ ACTUEL DATE ☐ PLANNED DATE (Year / Month / Day)

If you spent other periods of **more than 21 consecutive days** outside Québec during the calendar year (January 1 to December 31), please specify:

REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)

- ☐ **Vacation or seasonal absence**
- ☐ **Work** — Employer's name
- ☐ **Studies** — Attach a written attestation from the educational institution showing the beginning and end dates of your courses, unless you have already done so.
- ☐ **Receipt of healthcare not available in Québec** — Régie's authorization number
- ☐ **Permanent move outside Québec** — Date of move (Year / Month / Day)
- ☐ **Other** — Specify

	Date of departure (Year / Month / Day)	Date of return (Year / Month / Day)
1st PERIOD		
2nd PERIOD		
3rd PERIOD		

HEALTHCARE SERVICES RECEIVED

Give the reason for which you received these healthcare services

IN THE CASE OF AN ACCIDENT, SPECIFY THE TYPE OF ACCIDENT

☐ Automobile ☐ Work ☐ Other (specify)

Date of accident (Year / Month / Day)

Describe the services received (examinations, x-rays, surgery, etc.). If you need more space, use a separate sheet.

WHERE DID YOU RECEIVE THESE SERVICES?

MUNICIPALITY / CANADIAN PROVINCE OR U.S. STATE / COUNTRY

If applicable, indicate the number of days you were hospitalized:

REIMBURSEMENT

Amount claimed

Canadian dollars ☐ Other currency ☐ SPECIFY:

Have you paid the bills? ☐ No ☐ Yes ☐ In full ☐ In part

AMOUNT PAID **(enclose originals of receipts)**

TRAVEL INSURANCE

Were you covered by travel insurance when you received the services?

☐ No ☐ Yes — NAME OF INSURANCE COMPANY

POLICY NUMBER

SIGNATURE AND AUTHORIZATION

☐ I hereby authorize the Régie de l'assurance maladie du Québec to provide to and receive from my travel insurance company all the information and documents required for the assessment and payment of my claims for insured medical and hospital services that I received and, if applicable, that my spouse or children received (family insurance).

☐ I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or facility any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CNESST with a copy of any documents I may sent to or receive from the Régie.

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT / RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN ETC.) / **SIGNATURE** X (YEAR / MONTH / DAY)

1896 266 16/09

APPLICATION FOR REIMBURSEMENT

You have **one year** from the date the services were provided to apply for a reimbursement for the cost of medical, dental or optometric services and **three years** for hospital services.

To apply, complete one form per person and indicate the person's Health Insurance Number.

In the case of a child under 12 months of age who has not yet received a Health Insurance Card, indicate the child's last name, first name, date of birth and sex, and enter the father's or mother's Health Insurance Number.

SUPPORTING DOCUMENTS

Please submit the **originals of your bills.**

The following must appear clearly:

- the name, address and signature of the health professional who rendered the services;
- the name and address of the facility where the services were provided, and signature of the authorized person;
- a detailed description of the services received;
- the date of and the fees for each service.

Send the **summary of your medical record** if you were hospitalized, and the **operative report** if you had major surgery.

You must provide **proofs of payment**, e.g. credit card receipts and photocopies of both sides of cashed **cheques**, indicating the name of the hospital or healthcare professional.

In addition, you must attach a French translation of the required documents if they are in a language other than French and English. If it considers it necessary, the Régie may request a certified translation at your expense.

Neither the originals nor photocopies of documents are returned by the Régie.

HOME ADDRESS

This form cannot be used to make a change of address. Please make any necessary changes using the Service québécois de changement d'adresse, available at **https://www.adresse.gouv.qc.ca**.

FOR FURTHER INFORMATION

Go to our website at:

www.ramq.gouv.qc.ca

You may also obtain information by calling:

in Québec
418 646-4636

in Montréal
514 864-3411

Elsewhere in Québec
1 800 561-9749

By mail
Régie de l'assurance maladie du Québec
Case postale 6600
Québec (Québec) G1K 7T3

Opening hours
Monday, Tuesday, Thursday and Friday: 8:30 a.m. to 4:30 p.m.
Wednesday: 10:00 a.m. to 4:30 p.m.

MAILING ADDRESS

Send the *Application for Reimbursement* and all required supporting documents (not stapled), to the following address:

Régie de l'assurance maladie du Québec
SAPHQAT
Case postale 6600
Québec (Québec) G1K 7T3

For more detailed information, visit our website.