Régie de l'assurance maladie Québec

Application for Reimbursement
External Breastforms Program

PLEASE LEAVE THIS SPACE BLANK

1. Identity of the insured person

Last name	Last name at birth (if different from the one already registered)	
First name	Health Insurance Number	Date of birth (Year / Month / Day)
Home address Number / Street		Apartment
Municipality		Postal code

2. Reason for the request

I underwent a ☐ **total**, ☐ **radical** ou ☐ **partial** mastectomy.

☐ **Left side**
Date of the operation (Year / Month / Day)

☐ **Right side**
Date of the operation (Year / Month / Day)

Please attach the ORIGINALS of the following documents:

- The detailed invoice and proof of payment for your external breastform (the purchase must have been made in Québec)
- The medical prescription (for your first application)

I have a total absence of breast formation (aplasia).

☐ **Left side**
Date of the medical report (Year / Month / Day)

☐ **Right side**
Date of the medical report (Year / Month / Day)

Please attach the ORIGINALS of the following documents:

- The detailed invoice and proof of payment for your external breastform (the purchase must have been made in Québec)
- The medical prescription (for your first application)

3. Signature of the insured person

I wish to receive the reimbursement provided under the External Breastforms Program.
I hereby declare that the information I have supplied is accurate and complete.

X _____ (Signature)

Date (Year / Month / Day)

Home telephone
Area code

Work telephone
Area code

Extension

Send the form and required documents to the following address:

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

We recommend that you keep copies of the documents that you send to the Régie. Other documents necessary for the assessment of your application may be required.