OUT-OF-PROVINCE CLAIM FOR PHYSICIAN SERVICES

SPACE RESERVED FOR ADMINISTRATIVE PURPOSES

A 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 / GUARDIAN | RELATIONSHIP TO PATIENT

DATE OF DEPARTURE FROM HOME PROVINCE/TERRITORY YEAR MONTH DAY | DATE OF RETURN TO HOME PROVINCE/TERRITORY YEAR MONTH DAY | PLACE WHERE TREATED (PROVINCE, 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 ☐ BUSINESS ☐ 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 a beneficiary of the Medical Care Plan in 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 To be completed by Health Professional *(please type or print clearly)*

HEALTH PROFESSIONAL'S LAST NAME | FIRST NAME | ☐ GENERAL PRACTITIONER ☐ SPECIALIST SPECIALITY _____

NAME OF BUSINESS (IF APPLICABLE) | IF APPLICABLE ☐ ANESTHETIST ☐ SURGICAL ASSISTANT ☐ PSYCHIATRIST | 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 ITS SERVICES WERE USED | ADMISSION DATE YEAR MONTH DAY | DISCHARGE DATE YEAR MONTH DAY

D Description of services delivered

Place where the services were rendered

PROCEDURE/TREATMENT	FEE CODE	FEE	DATE OF SERVICE YEAR MONTH DAY	TIME HRS MINS	OFFICE	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	EMERGENCY ROOM	HOME
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

DIAGNOSIS AND OTHER REMARKS

CLAIM INVOLVES: ☐ WORK ACCIDENT ☐ AUTOMOBILE ACCIDENT | DATE OF ACCIDENT YEAR MONTH DAY | ☐ OTHER : (specify) _____

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

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