Out of Province Claim for Physician Services

(reserved for administration)

A. To be completed by the Patient or Parent / Gurdian of Patient *(please type or print clearly)*

Patient's last name on Health Card | First name | Initials | Medicare no.

Permanent mailing address | Date of expiry

Municipality | Province/territory | Postal code

Date of birth | Sex | Name of parent / Guardian | Relationship to patient

Date of departure from home province/territory | Place where treated (province, territory) **Quebec** | Date of arrival

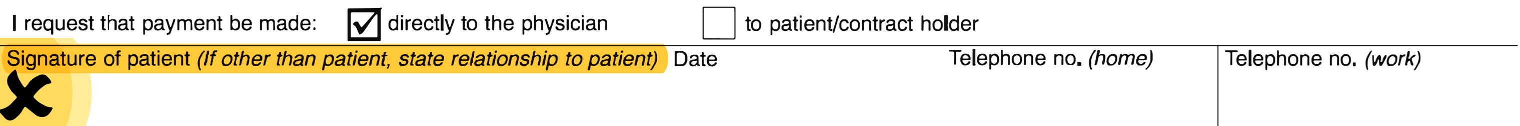
Is this a permanent move? ☐ Yes | If no, specify date of return to home province/territory

Reason for absence from home: ☐ vacation ☑ study | Name of institution **Concordia University** | ☐ business ☐ other *(specify)*

B. Declaration of Patient or Parent / Guardian of Patient

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 ______________________

I request that payment be made: ☑ directly to the physician ☐ to patient/contract holder



Signature of patient *(If other than patient, state relationship to patient)* | Date | Telephone no. *(home)* | Telephone no. *(work)*

C. To be completed by Physician *(please type or print clearly)*

Physician's name | Initials | Specialty ☑ certified ☐ non-certified

Address | If ☐ Anaesthetist ☐ Surgical Assistant ☐ Psychiatrist | Provide duration of service Hrs. Min.

Name of referring physician | Speciality

Postal Code | Services provided in ☐ Office ☐ Home ☐ Hospital out-patient ☐ Hospital in-patient

If hospital services, please provide: Name of hospital | Address | Admission date yyyy mm dd | Discharge date yyyy mm dd

If claiming in-patient care, please indicate service dates

Service date(s)	Year	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Year	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Procedure/Treatment	Fee code	Fee	Date of service mm dd	Time	For Office Use Only		

Diagnosis and other remarks

Claims involves: ☐ Workers' compensation ☐ pensionable disability ☐ automobile accident ☐ other third party

☑ Pay physician – I accept the patient's plan payment as payment in full ☐ Pay patient

Physician's signature | Date | Language of correspondence ☑ English ☐ French