OUT-OF-PROVINCE CLAIM FOR PHYSICIAN/ PRACTITIONER SERVICES

SPACE PROVIDED FOR ADMINISTRATIVE PURPOSES

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

PATIENT'S SURNAME ON HEALTH CARD | FIRST NAME | INITIALS | HEALTH CARE NUMBER

PERMANENT MAILING ADDRESS | DATE OF EXPIRY

CITY | PROVINCE/TERRITORY | POSTAL CODE

BIRTHDATE YEAR MONTH DAY | SEX ☐ M ☐ F | NAME OF PARENT / GUARDIAN | RELATIONSHIP TO PATIENT

DATE OF DEPARTURE FROM HOME YEAR MONTH DAY | PLACE WHERE TREATED (PROVINCE, TERRITORY) | DATE OF ARRIVAL YEAR MONTH DAY | IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | IF NO, SPECIFY DATE OF RETURN HOME YEAR MONTH DAY

GIVE REASON FOR ABSENCE FROM HOME: ☐ VACATION ☐ STUDY | NAME OF INSTITUTION | ☐ BUSINESS ☐ OTHER | PLEASE 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/practitioner ☐ to patient/contract holder ☐

SIGNATURE OF PATIENT (If other than patient, state relationship to patient) | DATE | TELEPHONE NO. (Home) AREA CODE ( ) | TELEPHONE NO. (Work) AREA CODE ( ) EXT.

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

PHYSICIAN'S/PRACTITIONER'S NAME AND INITIALS | SPECIALITY ☐ CERTIFIED ☐ NON-CERTIFIED

ADDRESS | CHECK HERE IF: ☐ ANAESTHETIST ☐ SURGICAL ASSISTANT ☐ PSYCHIATRIST | PROVIDE DURATION OF SERVICE HRS MINS

NAME OF REFERRING PHYSICIAN/PRACTITIONER *(IF APPLICABLE)* | SPECIALTY

POSTAL CODE | SERVICES PROVIDED IN: ☐ OFFICE ☐ HOME ☐ HOSPITAL OUT-PATIENT ☐ HOSPITAL IN-PATIENT

IF HOSPITAL SERVICES, PLEASE PROVIDE: NAME OF HOSPITAL / ADDRESS | ADMISSION DATE YEAR MONTH DAY | DISCHARGE DATE YEAR MONTH DAY

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
			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 YEAR MONTH DAY	TIME	FOR OFFICE USE ONLY

DIAGNOSIS AND OTHER REMARKS

CLAIM INVOLVES:
☐ WORKERS' COMPENSATION ☐ PENSIONABLE DISABILITY
☐ AUTOMOBILE ACCIDENT ☐ OTHER THIRD PARTY

☐ PAY PHYSICIAN/PRACTITIONER ☐ PAY PATIENT ☐ OTHER (SPECIFY) _____
I accept the patient's plan payment as payment in full

PHYSICIAN'S/PRACTITIONER'S SIGNATURE | DATE | LANGUAGE OF CORRESPONDENCE ☐ ENGLISH ☐ FRENCH