Out of Province Claim for Physician Services

(reserved for administration)

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Date of birth					Name of parent / Guardian								R	Relationship to patient							
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Is this a permanent move? Yes No				If no, specify date of return to home province/territory						уу	уу		п	ım	dd						
Reason for absen	ce from home			Name o	f insti	tution				Пр	usines	s	Г	70	ther	specif					
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Signature of patier	nt (If other than pa	atient,	state	relation	ship t	o patieni	ent) Date				Telep	Telephone no. (ho			nome) Te			Telephone no. (work)			
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C To be co	mpleted by P	hysi	cian	(pleas	se ty	pe or p	rint	clearly)													
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f hospital	Name of hospita		ostal	Code		Na	me o	f referring p	physicia			miss	ion d	pital ate	out-	patient	Spec	Hrs. iality		l in-pa	tient
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