

Out of Province Claim for Physician Services

(reserved for administration)

A To be completed by the Patient or Parent / Guardian 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 yyyy mm dd	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Name of parent / Guardian		Relationship to patient
Date of departure from home province/territory yyyy mm dd	Place where treated (province, territory)		Date of arrival yyyy mm dd	
Is this a permanent move? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, specify date of return to home province/territory yyyy mm dd		
Reason for absence from home <input type="checkbox"/> vacation <input type="checkbox"/> study		Name of institution <input type="checkbox"/> business <input type="checkbox"/> other (specify) _____		

B Declaration of Patient or Parent / Guardian 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) () ()
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C To be completed by Physician (please type or print clearly)

Physician's name		Initials	Specialty <input type="checkbox"/> certified <input type="checkbox"/> non-certified	
Address		If <input type="checkbox"/> Anaesthetist <input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Psychiatrist		Provide duration of service Hrs. Min.
		Name of referring physician		Speciality
Postal Code		Services provide in <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital out-patient <input type="checkbox"/> Hospital in-patient		
If hospital services, please provide:	Name of hospital		Admission date yyyy mm dd	Discharge date yyyy mm dd
	Address			

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 yy mm dd	Time	For Office Use Only			

Diagnosis and other remarks		
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Claims involves: <input type="checkbox"/> Workers' compensation <input type="checkbox"/> automobile accident	<input type="checkbox"/> pensionable disability <input type="checkbox"/> other third party	<input type="checkbox"/> Pay physician – I accept the patient's plan payment as payment in full <input type="checkbox"/> Pay patient
Physician's signature		Date
		Language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French