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	Name of parent / Guardian	Relationship to patient
	☐ M ☐ F		

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?	If no, specify date of return to home province/territory (yyyy mm dd)
☐ Yes ☐ No	

Reason for absence from home
☐ vacation ☐ study ☐ business ☐ other *(specify)* _____

Name of institution

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)*
		( )	( )

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 provide in ☐ Office ☐ Home ☐ Hospital out-patient ☐ 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

	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
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

Procedure/Treatment	Fee code	Fee	Date of service (yy 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