Out-of-Province Claim

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

Patient's Surname	First Name	Initials	Medicare Number

Permanent Mailing Address	City	Province/State	Postal/Zip Code

Temporary Mailing Address	City	Province/State	Postal/Zip Code

Birthdate (Year/Month/Day)	Sex ☐ M ☐ F	Maiden/Birth Name	Name of Head of Household	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	Date of Return Home (Year/Month/Day)

Give reason for absence from home: ☐ Vacation ☐ Business ☐ Study (Name of Institution)_____ ☐ Other

Section B Declaration of Patient or Parent/Guardian of the 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 of _____.

I request that payment be made: ☐ directly to the treating physician ☐ to the patient/contract holder ☐ to a third party

IF Third Party: Surname	First Name	Initials

Address	City	Province/State	Postal/Zip Code

Signature of Patient (if other than patient, state relationship to patient)	Date	Telephone No. (Home)	Telephone No. (Work)

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

Physician's Name and Initials	Specialty	☐ Certified ☐ Non-Certified

Address	City	Province/State	Postal/Zip Code

If ☐ Anaesthetist ☐ Surgical Assistant ☐ Psychiatrist Provide Duration of Service: Hours_____ Minutes_____

Name of Referring Physician	Services Provided in: ☐ Office ☐ Home ☐ Hospital Out-Patient ☐ Hospital In-Patient	Invoice Number

If Hospital Services: Name of Hospital	Admission Date (Year/Month/Day)	Discharge Date (Year/Month/Day)

Address	City	Province/State	Postal/Zip Code

IF CLAIMING IN-PATIENT CARE, PLEASE INDICATE SERVICE DATES

Service Date(s)	Month	Year	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)	Duration	**For Office Use Only**

Diagnosis and Other Remarks	

Claim Involves: ☐ Workers' Compensation ☐ Pensionable Disability ☐ Automobile Accident ☐ Other Third Party	☐ Pay Patient ☐ Pay Physician - I accept the patient's plan payment as payment in full.	
	Physician's Signature / Date	Language of Correspondence ☐ French ☐ English

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