

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 <input type="checkbox"/> M <input type="checkbox"/> F | NAME OF PARENT / GUARDIAN | RELATIONSHIP TO PATIENT |
|-----------------------------|--|---------------------------|-------------------------|

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|---|---|-----------------------------------|---|--|
| DATE OF DEPARTURE FROM HOME YEAR MONTH DAY | PLACE WHERE TREATED (PROVINCE, TERRITORY) | DATE OF ARRIVAL YEAR MONTH DAY | IS THIS A PERMANENT MOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO | IF NO, SPECIFY DATE OF RETURN HOME YEAR MONTH DAY |
|---|---|-----------------------------------|---|--|

GIVE REASON FOR ABSENCE FROM HOME: VACATION STUDY BUSINESS OTHER

NAME OF INSTITUTION _____ 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)

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| PHYSICIAN'S/PRACTITIONER'S NAME AND INITIALS | SPECIALITY <input type="checkbox"/> CERTIFIED <input type="checkbox"/> NON-CERTIFIED |
| ADDRESS | CHECK HERE IF: <input type="checkbox"/> ANAESTHETIST <input type="checkbox"/> SURGICAL ASSISTANT <input type="checkbox"/> PSYCHIATRIST |
| | PROVIDE DURATION OF SERVICE HRS _____ MINS _____ |
| | NAME OF REFERRING PHYSICIAN/PRACTITIONER (IF APPLICABLE) _____ SPECIALTY _____ |
| POSTAL CODE | SERVICES PROVIDED 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 _____ 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 |
|---------------------|----------|-----|-----------------------------------|------|---------------------|
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DIAGNOSIS AND OTHER REMARKS _____

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| CLAIM INVOLVES: <input type="checkbox"/> WORKERS' COMPENSATION <input type="checkbox"/> PENSIONABLE DISABILITY <input type="checkbox"/> AUTOMOBILE ACCIDENT <input type="checkbox"/> OTHER THIRD PARTY | <input type="checkbox"/> PAY PHYSICIAN/PRACTITIONER <input type="checkbox"/> PAY PATIENT <input type="checkbox"/> OTHER (SPECIFY) _____ I accept the patient's plan payment as payment in full | LANGUAGE OF CORRESPONDENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH |
| PHYSICIAN'S/PRACTITIONER'S SIGNATURE _____ | | DATE _____ |