OUT-OF-PROVINCE CLAIM FOR PHYSICIAN SERVICES

SPACE RESERVED FOR ADMINISTRATIVE PURPOSES

A To be completed by Patient or Representative *(please type or print clearly)*

PATIENT'S LAST NAME ON HEALTH CARD | FIRST NAME | MEDICARE NUMBER

PERMANENT MAILING ADDRESS | CARD EXPIRY DATE

MUNICIPALITY | PROVINCE/TERRITORY: Quebec | POSTAL CODE

BIRTHDATE (YEAR / MONTH / DAY) | SEX: ☐ M ☐ F | NAME OF PARENT / GUARDIAN | RELATIONSHIP TO PATIENT

DATE OF DEPARTURE FROM HOME PROVINCE/TERRITORY (YEAR / MONTH / DAY) | DATE OF RETURN TO HOME PROVINCE/TERRITORY (YEAR / MONTH / DAY) | PLACE WHERE TREATED (PROVINCE, TERRITORY): Ontario | IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | IF NO, SPECIFY DATE OF RETURN TO HOME PROVINCE/TERRITORY (YEAR / MONTH / DAY)

GIVE REASON FOR ABSENCE FROM HOME: ☐ VACATION ☐ STUDY ☐ BUSINESS ☐ OTHER: (specify) _____

B Declaration of Patient or Representative

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 Quebec

SIGNATURE OF PATIENT (If other than patient, state relationship to patient) X _____ | DATE (YEAR / MONTH / DAY) | TELEPHONE NO. (Work) AREA CODE ( ) | TELEPHONE NO. (Home) AREA CODE ( )

C To be completed by Health Professional *(please type or print clearly)*

HEALTH PROFESSIONAL'S LAST NAME | FIRST NAME | ☐ GENERAL PRACTITIONER ☐ SPECIALIST SPECIALITY _____

NAME OF BUSINESS (IF APPLICABLE): University of Toronto - FKPE; David L. MacIntosh Sport Medicine Clinic | IF APPLICABLE: ☐ ANESTHETIST ☐ SURGICAL ASSISTANT ☐ PSYCHIATRIST | DURATION OF TREATMENT HRS / MINS

ADDRESS NUMBER: 4th Floor | STREET: 100 Devonshire Place | MUNICIPALITY: Toronto | NAME OF REFERRING PHYSICIAN

PROVINCE OR TERRITORY: Ontario | POSTAL CODE: M5S 2C9 | TELEPHONE NUMBER AREA CODE: 416 978 - 4678 | SPECIALITY

☐ PAYMENT TO HEALTH PROFESSIONAL ☐ REIMBURSEMENT TO PATIENT ☒ PAYMENT TO BUSINESS

NAME AND ADDRESS OF HOSPITAL IF ITS SERVICES WERE USED | ADMISSION DATE (YEAR / MONTH / DAY) | DISCHARGE DATE (YEAR / MONTH / DAY)

D Description of services delivered

PROCEDURE/TREATMENT	FEE CODE	FEE	DATE OF SERVICE (YEAR MONTH DAY)	TIME	Place where the services were rendered: OFFICE	HOSPITAL OUT-PATIENT	HOSPITAL IN-PATIENT	EMERGENCY ROOM
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

DIAGNOSIS AND OTHER REMARKS

CLAIM INVOLVES: ☐ WORK ACCIDENT ☐ AUTOMOBILE ACCIDENT | DATE OF ACCIDENT (YEAR / MONTH / DAY) | ☐ OTHER : (specify) _____

I accept the patient's plan payment as payment in full.

HEALTH PROFESSIONAL'S SIGNATURE X _____ | DATE (YEAR / MONTH / DAY) | LANGUAGE OF CORRESPONDENCE ☐ FRENCH ☒ ENGLISH