

OUT-OF-PROVINCE CLAIM

SECTION A PATIENT INFORMATION (To Be Completed By Patient or Parent/Guardian) – PLEASE PRINT CLEARLY					
Patient Surname		All Given Names		MCP Number	
Surname at Birth (if different from above)		Date of Birth YYYY MM DD	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Telephone Number	Email Address
PERMANENT Mailing Address: Street / P.O. Box			City / Town	Province	Postal Code
TEMPORARY Mailing Address: Street / P.O. Box			City / Town	Province / State	Postal / Zip Code
Date of Departure From Home 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	Date of Return Home YYYY MM DD
Reason for Absence From Home: <input type="checkbox"/> Vacation <input type="checkbox"/> Business <input type="checkbox"/> Study – Name of Institution _____ <input type="checkbox"/> Other – Specify _____					
DECLARATION 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 Newfoundland & Labrador Medical Care Plan.					
Signature of Patient (or parent/guardian, if applicable): _____ Date: _____					
Parent/guardian signature required if patient is less than 16 years of age. If signed by other than patient, please state relationship to patient. _____					
SECTION B PAYMENT INFORMATION					
Payment should be made to: <input type="checkbox"/> Treating physician <input type="checkbox"/> Patient / contract holder <input type="checkbox"/> Third party – Specify _____					
Address of Third Party (if applicable): Street / P.O. Box			City / Town	Province / State	Postal / Zip Code
SECTION C PHYSICIAN / TREATMENT INFORMATION (To Be Completed By Physician) - PLEASE PRINT CLEARLY					
Physician Surname		All Given Names		Specialty <input type="checkbox"/> Certified <input type="checkbox"/> Non-Certified	
Street / P.O. Box		City / Town	Province / State	Postal / Zip Code	
Name of Referring Physician		Services Provided In: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital In-Patient <input type="checkbox"/> Hospital Out-Patient			
If <input type="checkbox"/> Anesthetist <input type="checkbox"/> Surgical Assist <input type="checkbox"/> Psychiatrist Provide duration of service: Hours _____ Minutes _____					
IF HOSPITAL SERVICES: Name of Hospital			Admission Date YYYY MM DD	Discharge Date YYYY MM DD	
Street / P.O. Box		City / Town	Province / State	Postal / Zip Code	
Procedure / Treatment	Fee Code	Fee	Date of Service YYYY MM DD	Duration	For Office Use Only
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
Diagnosis and Other Remarks					
Claim Involves: <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Pensionable Disability <input type="checkbox"/> Automobile Accident <input type="checkbox"/> Other Third Party		Physician's Signature		Date	Language of Correspondence <input type="checkbox"/> English <input type="checkbox"/> French

PLEASE PROVIDE ORIGINAL DOCUMENTATION

PRIVACY NOTICE

Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.