Régie de l'assurance maladie Québec

# APPLICATION FOR REIMBURSEMENT

Before completing this form, refer to the Régie's pamphlet entitled *Healthcare Services Covered Outside Québec*, or visit our website at **www.ramq.gouv.qc.ca**

FOR OFFICE USE

CHECK THE APPROPRIATE BOX ▶ Healthcare services received: ☐ in Canada ☐ outside Canada

## APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER (LETTERS / NUMBERS)

LAST NAME

LAST NAME (AS APPEARING ON HEALTH INSURANCE CARD)

FIRST NAME

DATE OF BIRTH (YEAR / MONTH / DAY)

SEX ☐ M ☐ F

**1** HOME ADDRESS IN QUÉBEC
NO. STREET APT. LOCALITY
PROVINCE POSTAL CODE PHONE NUMBER AT HOME AREA CODE PHONE NUMBER AT WORK AREA CODE

**2** ADDRESS FOR CORRESPONDENCE OR PAYMENT, IF DIFFERENT THAN ADDRESS 1
NO. STREET APT. LOCALITY
PROVINCE OR STATE AND COUNTRY POSTAL CODE PHONE NUMBER AT HOME AREA CODE PHONE NUMBER AT WORK AREA CODE

REIMBURSEMENT CHEQUE *TO BE MAILED TO:* ☐ ADDRESS 1 ☐ ADDRESS 2

INQUIRIES TO BE SENT TO: ☐ ADDRESS 1 ☐ ADDRESS 2

## PERIODS OF TIME SPENT OUTSIDE QUÉBEC

**Period during which you received healthcare services**

Date of departure from Québec (YEAR / MONTH / DAY)

Date of return to Québec ☐ ACTUAL DATE ☐ PLANNED DATE (Year / Month / Day)

REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)

- ☐ Vacation or seasonal absence
- ☐ Work — Employer's name: .....
- ☐ Studies — Attach a written attestation from the educational institution showing the *beginning* and end dates of your courses, unless you have already done so.
- ☐ Receipt of healthcare not available in Québec — Régie's authorization number .....
- ☐ Permanent move — ☐ Within Canada ☐ Outside Canada — Date of move (Year / Month / Day)
- ☐ Other — Specify .....

**If you spent other periods of more than 21 consecutive days outside Québec during the calendar year** (January 1 to December 31), **please specify:**

1st PERIOD — Date of departure (Year / Month / Day) | (Year / Month / Day)

2nd PERIOD — Date of departure | (Year / Month / Day)

3rd PERIOD — Date of departure | Date of return (Year / Month / Day)

## HEALTHCARE SERVICES RECEIVED

Give the reason for which you received these healthcare services

**IN THE CASE OF AN ACCIDENT,** SPECIFY THE TYPE OF ACCIDENT

☐ Automobile ☐ Work ☐ Other (specify) — Date of accident

Describe the services received (examinations, x-rays, surgery, etc.). If you need more space, use a separate sheet.

**WHERE DID YOU RECEIVE THESE SERVICES?**

LOCALITY | CANADIAN PROVINCE OR U.S. STATE | COUNTRY

**If applicable,** indicate the number of days you were hospitalized:

## REIMBURSEMENT

Amount claimed . . . . . | Canadian dollars ☐ | Other currency ☐ SPECIFY:

Have you paid the bills? ☐ No ☐ Yes ▶ ☐ In full ☐ In part

AMOUNT PAID (enclose originals of receipts)

## SUPPORTING DOCUMENTS

If you did not have travel insurance when you received the services, send all required documents to the Régie.

If you did have travel insurance when you received the services, **check whether your insurance company will apply to the Régie for a reimbursement on your behalf.**

**If so,** send all required documents to the insurance company.

**If not,** send all necessary documents to the Régie.

NAME OF INSURANCE COMPANY | POLICY NUMBER

## SIGNATURE AND AUTHORIZATION

I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or institution any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

*If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CSST with a copy of any documents I may sent to or receive from the Régie.*

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT | RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN , ETC.)

SIGNATURE (Year / Month / Day)

☐ ENGLISH ☐ FRENCH