Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

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	Maiden/Birth Name	Name of Head of Household	Relationship to Patient
	M ☐ F ☐			

Date of Departure from Home Year / Month / Day	Place Where Treated (Province, Territory)	Date of Arrival Year / Month / Day	Is this a permanent move?	Date of Return Home Year / Month / Day
			Yes ☐ No ☐	

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	Home Telephone	Work Telephone

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 Assist ☐ Psychiatrist Provide duration of service: Hours _____ Minutes _____

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

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

Address	City	Province/State	Postal/Zip Code

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
			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
			/ /		
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Diagnosis and Other Remarks

Claim Involves:
□ Workers' Compensation □ Pensionable Disability
□ Automobile Accident □ Other Third Party

□ Pay Patient □ Pay Physician – I accept the patient's payment plan as payment in full.

Physician's Signature Date

Language of Correspondence
□ English □ French

Please provide original documentation.