



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																								
Year		Birthdate Month		Day		Sex M <input type="checkbox"/> F <input type="checkbox"/>		Maiden/Birth Name		Name of Head of Household		Relationship to Patient																						
Date of Departure from Home Year			Month			Day			Place Where Treated (Province, Territory)		Date of Arrival Year																							
									Is this a permanent move? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of Return Home Year																							
Give reason for absence from home: <input type="checkbox"/> Vacation <input type="checkbox"/> Business <input type="checkbox"/> Study (Name of Institution) _____ <input type="checkbox"/> 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: <input type="checkbox"/> Directly to the treating physician <input type="checkbox"/> To the patient/contract holder <input type="checkbox"/> 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			<input type="checkbox"/> Certified			<input type="checkbox"/> Non-Certified																						
Address				City			Province/State			Postal/Zip Code																								
If <input type="checkbox"/> Anaesthetist <input type="checkbox"/> Surgical Assist <input type="checkbox"/> Psychiatrist Provide duration of service: Hours _____ Minutes _____																																		
Name of Referring Physician						Services Provided in:			Invoice Number																									
						<input type="checkbox"/> Office <input type="checkbox"/> Hospital In-Patient																												
						<input type="checkbox"/> Home <input type="checkbox"/> Hospital Out-Patient																												
If Hospital Services: Name of Hospital						Admission Date Year			Discharge Date Year																									
						Month			Month																									
						Day			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	
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: <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 Patient <input type="checkbox"/> Pay Physician – I accept the patient's payment plan as payment in full.																												
						Physician's Signature			Date			Language of Correspondence <input type="checkbox"/> English <input type="checkbox"/> French																						

****Please provide original documentation.****