

Claim for Payment
Outpatient services rendered
to residents of Québec
(to be used by hospitals excluded from
interprovincial billing)

LEAVE THIS SPACE BLANK

External control number

1- Facility

FACILITY CODE	NAME OF FACILITY	
ADDRESS (number, street, locality)		PROVINCE
		POSTAL CODE

2- Details of claim

HEALTH INSURANCE NUMBER	INSURED PERSON'S LAST AND FIRST NAME ON CARD (IN BLOCK LETTERS)		SERVICE CODE	RATE FOR SERVICE
EXPIRY DATE OF CARD YEAR MONTH NEWBORN <input type="checkbox"/>	DATE OF BIRTH YEAR MONTH DAY	SEX M/F	SERVICE DATE YEAR MONTH DAY	
A DIAGNOSTIC CODE				
INTERVENTION CODE				
INTERVENTION ATTRIBUTES STATUS LOCATION EXTENT		STATUS LOCATION EXTENT		
ADDITIONAL INFORMATION, WHERE APPLICABLE				
EXPIRY DATE OF CARD YEAR MONTH NEWBORN <input type="checkbox"/>	DATE OF BIRTH YEAR MONTH DAY	SEX M/F	SERVICE DATE YEAR MONTH DAY	
B DIAGNOSTIC CODE				
INTERVENTION CODE				
INTERVENTION ATTRIBUTES STATUS LOCATION EXTENT		STATUS LOCATION EXTENT		
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C DIAGNOSTIC CODE				
INTERVENTION CODE				
INTERVENTION ATTRIBUTES STATUS LOCATION EXTENT		STATUS LOCATION EXTENT		
ADDITIONAL INFORMATION, WHERE APPLICABLE				

3- Attestation by facility

The person signing this form on behalf of the facility attests that the above information is accurate.

Last name and first name of authorized person

Signature of authorized person

(IN BLOCK LETTERS)

YEAR MONTH DAY