OUT-OF-PROVINCE CLAIM
FOR PHYSICIAN SERVICES

A To be completed by Patient or Representative *(please type or print clearly)*

PATIENT'S LAST NAME ON HEALTH CARD

FIRST NAME

PERMANENT MAILING ADDRESS

MUNICIPALITY

PROVINCE/TERRITORY

BIRTHDATE
YEAR MONTH DAY

SEX
M F

NAME OF PARENT / GUARDIAN

DATE OF DEPARTURE FROM HOME PROVINCE/TERRITORY
YEAR MONTH DAY

YEAR MONTH DAY

YEAR MONTH DAY

SIGNATURE OF PATIENT (If other than patient, state relationship to patient)

DATE

TELEPHONE NUMBER
AREA CODE

DATE OF ACCIDENT