Newfoundland Labrador
Health and Community Services

OUT-OF-PROVINCE CLAIM

mcp
Medical Care Plan

SECTION A | PATIENT INFORMATION (To Be Completed By Patient or Parent/Guardian) – PLEASE PRINT CLEARLY

Patient Surname	All Given Names	MCP Number	Card Expiry Date YYYY MM DD

Surname at Birth (if different from above)	Date of Birth YYYY MM DD	Sex ☐ Male ☐ Female	Daytime Telephone Number	Email Address

PERMANENT Mailing Address: Street / P.O. Box	City / Town	Province	Postal Code
TEMPORARY Mailing Address: Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

Date of Departure From Home YYYY MM DD	Place Where Treated (Province/Territory)	Date of Arrival YYYY MM DD	Is this a Permanent Move? ☐ Yes ☐ No	Date of Return Home YYYY MM DD

Reason for Absence From Home: ☐ Vacation ☐ Business ☐ Study – Name of Institution _____ ☐ Other – Specify _____

DECLARATION
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 Newfoundland & Labrador Medical Care Plan.

Signature of Patient (or parent/guardian, if applicable): _____ Date: _____

Parent/guardian signature required if patient is less than 16 years of age. If signed by other than patient, please state relationship to patient. _____

SECTION B | PAYMENT INFORMATION

Payment should be made to: ☐ Treating physician ☐ Patient / contract holder ☐ Third party – Specify _____

Address of Third Party (if applicable): Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

SECTION C | PHYSICIAN / TREATMENT INFORMATION (To Be Completed By Physician) - PLEASE PRINT CLEARLY

Physician Surname	All Given Names	Specialty ☐ Certified ☐ Non-Certified

Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

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

If ☐ Anesthetist ☐ Surgical Assist ☐ Psychiatrist Provide duration of service: Hours _____ Minutes _____

IF HOSPITAL SERVICES: Name of Hospital	Admission Date YYYY MM DD	Discharge Date YYYY MM DD

Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

Procedure / Treatment	Fee Code	Fee	Date of Service	Duration	For Office Use Only
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		

Diagnosis and Other Remarks

Claim Involves: ☐ Workers' Compensation ☐ Pensionable Disability ☐ Automobile Accident ☐ Other Third Party	Physician's Signature	Date	Language of Correspondence ☐ English ☐ French

PLEASE PROVIDE ORIGINAL DOCUMENTATION

PRIVACY NOTICE
Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.

Medical Care Plan
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