Out-of-Province Claim
Physician or Practitioner Services

OOPclaims.reclamDHP@gnb.ca

ALL FIELDS MARKED WITH AN ** ARE REQUIRED. THE FORM WILL NOT BE PROCESSED IF FIELDS REMAIN BLANK

Part 1: Patient Information

To be completed by the patient, or the patient's parent, or representative.

**PATIENT LAST NAME ON THE HEALTH CARD	**FIRST NAME	**NEW BRUNSWICK MEDICARE NUMBER
**PERMANENT MAILING ADDRESS		
MUNICIPALITY	PROVINCE/TERRITORY	POSTAL CODE

**BIRTHDATE YEAR – MONTH- DAY	SEX F ☐ M ☐ OTHER ☐	NAME OF THE PARENT/GUARDIAN	RELATIONSHIP
DATE OF DEPARTURE FROM HOME PROVINCE/TERITORY YEAR – MONTH- DAY	Please give the reason for absence Moved ☐ Vacation ☐ Work ☐ Study ☐ OTHERS ☐_____	PLACE WHERE TREATED (PROVINCE TERITORY)	IS THIS A PERMANENT MOVE? YES ☐ NO ☐ IF YES: DAY-MONTH-YEAR

Part 2: Practitioner Information

To be completed by the physician providing treatment and billing New Brunswick Medicare

**PRACTIONER LAST NAME	**NAME	PRCT. ID	☐SPECIATLY __ _____ ☐ASSISTANT ☐GENERAL PRACTITIONER ☐ ANES:	DURATION OF TREATMENT Hours Minutes
**MAILING ADDRESS	**MUNICIPALITY		REFERRING PRACTITIONER SPECIATLY:	
**PROVINCE	**POSTAL CODE	PHONE NUMBER		
Payable to: **☐Practitioner ☐Patient ☐Other _____**				
IF THE PATIENT RECEIVED SERVICES IN A HOSPITAL, PLEASE PROVIDE ADDITIONAL INFORMATION FOR THE HOSPITAL STAY NAME AND ADDRESS OF THE HOSPITAL:			ADMISSION DATE: YEAR – MONTH- DAY	DISCHARGE DATE: YEAR – MONTH- DAY

Part 3: Treatment Information (MUST be fully completed)

To be completed by the practitioner providing treatment.

**Service Date	**Service Description	**Service Code	MOD	**Fee	Time	Office	Home	Inpatient	Out -patient	
						☐	☐	☐	☐	
						☐	☐	☐	☐	
						☐	☐	☐	☐	
						☐	☐	☐	☐	
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						☐	☐	☐	☐	
						☐	☐	☐	☐	

**Diagnosis	**Claim invoices:** ☐ **Worker's Compensation** ☐ **Pensionable Disability** ☐ **Automobile Accident** ☐ **Other** _____

Part 4: Declaration

Please send your completed claim form along with proof of payment and clear copies of itemized statements of practitioner and hospital charges on the statement or letter from the out-of-province health service provider. Please submit your claim by email at MedOOP.Eclaims@gnb.ca

I declare that the information I have provided on this form is correct to the best of my knowledge.

**Patient or Guardian's name: _____ **Date: _____ **Patient of Guardians Signature: _____

**Practitioner's Name: _____ **Date: _____ **Practitioner's Signature: _____

Medicare has the authority to collect the information you will provide in this form, under subsections 21(1) and 34 (1) of the Personal Health Information Privacy and Access Act, to process [payment requests for health services provided to eligible New Brunswick residents while outside New Brunswick. If you have any questions about the collection, use or disclosure of this information, please contact the Department of health Corporate Privacy Office at cpobpvp@gnb.ca