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 | Maiden / Birth Name (if applicable) |
|---|---|---|
| | | |

| MCP Number | Date of Birth YYYY MM DD | Gender ☐ M ☐ F ☐ X | 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: ____________

## SECTION B — PAYMENT INFORMATION

Payment should be made to: ☐ Treating physician ☐ Patient / contract holder ☑ Third party – Specify **MEDAVIE BLUE CROSS**

| Address of Third Party (if applicable): Street / P.O. Box | City / Town | Province / State | Postal / Zip Code |
|---|---|---|---|
| PO Box 220 | Moncton | N.B. | E1C 8L3 |