Out-of-Province Claim
Physician or Practitioner Services

MedOOP.EClaims@gnb.ca

Medicare has the authority to collect the information you will provide in this form, under subsections 27(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.

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

Part 1: Patient Information

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

**LAST NAME | **FIRST NAME | MIDDLE INITIAL

GENDER | **DATE OF BIRTH (**DAY | **MONTH | **YEAR) | **NEW BRUNSWICK MEDICARE NUMBER

PATIENT MAILING ADDRESS | CITY OR TOWN | PROVINCE | POSTAL CODE

GUARDIAN LAST NAME | GUARDIAN FIRST NAME | GUARDIAN MEDICARE NUMBER

PLEASE GIVE THE REASON FOR THE ABSENCE ☐ STUDY ☐ BUSINESS ☐ VACATION ☐ MOVED

DEPARTURE DATE FROM NEW BRUNSWICK | PROVINCE/TERRITORY WHERE TREATED

HAS THE PATIENT LEFT NB PERMANENTLY? ☐ YES ☐ NO

IF NO, WHEN WILL THE PATIENT RETURN? (DD-MM-YYYY) 2022-10-13

Part 2: Practitioner Information

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

**PRACTITIONER LAST NAME | **PRACTITIONER FIRST NAME | **PRACTITIONER ID

**SPECIALITY

**MAILING ADDRESS | **MUNICIPALITY | **PROVINCE | **POSTAL CODE

WHERE DID THE PATIENT RECEIVE SERVICES? ☐ OFFICE ☐ HOME ☐ HOSPTIAL* – INPATIENT ☐ HOSPITAL* - OUTPATIENT

* If the patient received services in a hospital, please provide additional information for the hospital stay below:

HOSPITAL NAME | HOSPITAL NUMBER | ADMISSION DATES | DISCHARGE DATE

HOSPITAL MAILING ADDRESS | MUNICIPALITY | PROVINCE | POSTAL CODE

Part 3: Treatment Information (MUST be fully completed)
To be completed by the practitioner providing treatment and billing New Brunswick Medicare

**SERVICE DESCRIPTION	**SERVICE CODE	**MODIFIERS	FEE	DATE OF SERVICE (DD/MM/YYYY)

**DIAGNOSIS & COMMENTS

CLAIM INVOICES:
- WORKER'S COMPENSATION
- PENSIONABLE DISABILITY
- AUTOMOBILE ACCIDENT
- OTHER

IF "OTHER", SPECIFY

PAYABLE TO:
- PRACTITIONER
- PATIENT
- OTHER

IF "OTHER", SPECIFY

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 official statement or letterhead 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 (DD-MM-YYYY)	**PATIENT OR GUARDIAN'S SIGNATURE

**PRACTITIONER'S NAME	**DATE (DD-MM-YYYY)	**PRACTITIONER'S SIGNATURE