



TYPE OF HOSPITALIZATION/SURGERY

- Planned hospitalization and/or surgery
- Hospitalization for a mental disorder
- Other emergency situations requiring hospitalization and/or surgery

IDENTIFICATION

Patient's name: _____ Student's Name: _____
Relationship to student: _____
Contract Number: _____ Group Number: _____
 Male Female Date of Birth (MM/DD/YYYY): _____

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis (including probability/possibility of complications): _____

When did symptoms first appear or accident happen? Date: (MM/DD/YYYY) _____

Has patient ever had same or similar condition? No Yes

If "yes", state when and describe: _____

Type of treatment: Surgery Therapy Other treatment plan

Describe the type of treatment and projected duration of treatment (if applicable): _____

Projected duration of hospitalization in days (if applicable): _____

Detail eventual fees that will be charged: _____

RAMQ code and cost for each procedure: _____

IN THE EVENT THAT THE REQUESTED INFORMATION IS UNOBTAINABLE SERVICES MAY BE REFUSED.

STATEMENT

Physician's name (Print): _____
Address: _____
Permit Number: _____ Telephone Number: _____
Fax Number: _____

I hereby certify that, to the best of my knowledge, the statement made above is complete and true.

Signature: _____ Date: _____

REPLY FROM MEDAVIE BLUE CROSS REGARDING THE PRE-AUTHORIZATION REQUEST FORM (see reverse)



REPLY FROM MEDAVIE BLUE CROSS REGARDING THE PRE-AUTHORIZATION REQUEST FORM (see reverse)

Your request is approved as described and stated fee charges will be paid up to the amounts specified in the current Provincial Schedule of fees of the "Régie de l'assurance maladie du Québec" and subject to an annual maximum, as stipulated in the contract.

RAMQ reimbursement

CODE	COST	CODE	COST
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

Your request is rejected due to the following: _____

We need the following details or documents before coming to a decision: _____

IN THE EVENT THAT THE REQUESTED INFORMATION IS UNOBTAINABLE SERVICES MAY BE REFUSED.

GROUP CLAIMS DEPARTMENT

Signature: _____ Date: _____