

chapter A-29, r. 7

Updated to 1 May 2017

Regulation respecting forms and statements of fees under the Health Insurance Act

Health Insurance Act

(chapter A-29, s. 72)

DIVISION I

DEFINITIONS

1. In this Regulation, the following expressions and words shall have the same meaning as that given them in the Health Insurance Act (chapter A-29):

- (a) Board;
- (b) *(paragraph revoked)*;
- (c) insured services;
- (d) professional in the field of health or professional;
- (e) insured person.

R.R.Q., 1981, c. A-29, r. 2, s. 1; O.C. 1471-92, s. 1.

2. In this Regulation, the following expressions and words have the same meaning as that given to them in the Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec (chapter A-29, r. 1), as it reads when applied:

- (a) resident of Québec or temporary resident of Québec;
- (b) dependent person;
- (c) spouse.

R.R.Q., 1981, c. A-29, r. 2, s. 2; O.C. 1471-92, s. 2; O.C. 553-2001, s. 1.

3. In this Regulation,

- (a) "data processing agency" means any person who gathers, processes or validates information or data by any form of data processing, and who has been duly authorized by a professional in the field of health to claim fees from the Board in his name, as well as any person who gives, loans, leases or in any way makes available data processing equipment or supplies to a professional in the field of health enabling him to acquire, process or validate information or data;
- (b) "application for accreditation" means any application sent by a professional in the field of health to the Board concerning the submitting of his statements of fees or claims by means of magnetic recording media or telecommunications, in accordance with Form 22;
- (c) "billing statement" means a statement of fees or claim, as the case may be, submitted to the Board by an accredited professional by means of magnetic recording media or telecommunications;
- (d) "data" means the information in the billing statement;
- (e) "agreement" means any agreement made pursuant of section 19 of the Act;
- (f) "Act" means the Health Insurance Act (chapter A-29);

(g) "manual" means the manual entitled Manuel de facturation par supports magnétiques et par télécommunication, published by the Board, establishing technical specifications necessary to bill the Board by magnetic recording media or telecommunications;

(h) "accredited professional" means any professional in the field of health whose application for accreditation has been accepted by the Board;

(i) "magnetic recording media" means tapes, diskettes, cassettes or any other form of data recording media which meet the technical specifications established by the Board and published in the manual.

R.R.Q., 1981, c. A-29, r. 2, s. 3; O.C. 413-85, s. 1; O.C. 1178-86, s. 1.

DIVISION II

APPLICATIONS FOR REGISTRATION

4. *(Revoked).*

R.R.Q., 1981, c. A-29, r. 2, s. 4; O.C. 1471-92, s. 3.

5. Professionals in the field of health: Every professional in the field of health legally authorized to provide insured services must register with the Board in accordance with the form and tenor of Form 2.

R.R.Q., 1981, c. A-29, r. 2, s. 5; O.C. 3017-82, s. 1; O.C. 553-87, s. 1.

6. *(Revoked).*

R.R.Q., 1981, c. A-29, r. 2, s. 6; O.C. 553-87, s. 2.

DIVISION III

HEALTH INSURANCE CARD

7. Issue: The Board shall issue a health insurance card to every resident of Québec or temporary resident of Québec duly registered with the Board.

R.R.Q., 1981, c. A-29, r. 2, s. 7; O.C. 1471-92, s. 4; O.C. 553-2001, s. 2.

8. Every health insurance card issued by the Board to an insured person must contain at least the following items:

(a) the insured person's health insurance number;

(b) the insured person's surname at birth and usual given name;

(c) the spouse's surname, if the insured person is a woman married in Québec before 2 April 1981, or married outside Québec, who legally exercises her civil rights under that name and wishes that name to appear on the health insurance card and if she makes the request in writing to the Board;

(d) the insured person's date of birth and sex;

(e) the expiry date of the card;

(f) the insured person's photograph;

(g) the insured person's signature, using his surname at birth and usual first name.

Notwithstanding the foregoing, the health insurance card shall not contain the insured person's photograph and signature where the insured person is less than 14 years of age.

R.R.Q., 1981, c. A-29, r. 2, s. 8; O.C. 56-82, s. 1; O.C. 1472-92, s. 1; O.C. 68-94, s. 1; O.C. 553-2001, s. 3.

8.0.1. The health insurance card shall not contain the insured person's photograph and signature in any of the following cases, unless the insured person furnishes to the Board his photograph and the authentication document duly completed in accordance with Division V of the Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec (chapter A-29, r. 1):

- (1) the insured person is 75 years of age or over;
- (2) the insured person is in residential care and subject to the contributory plan for adults in residential care in a facility operated by a public institution or a private institution under agreement;
- (3) the insured person is under tutorship or curatorship and is represented by the Public Curator Act in accordance with the Public Curator Act (chapter C-81);
- (4) the insured person resides in one of the locations listed in Schedule I.

O.C. 1472-92, s. 1; O.C. 68-94, s. 2.

8.0.2. The health insurance card may omit the insured person's photograph and signature where:

- (a) the insured person furnishes to the Board a medical certificate attesting that he is temporarily or permanently affected by a disease or a physical deficiency preventing him from moving about;
- (b) the insured person is a person referred to in section 7 of the Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec (chapter A-29, r. 1);
- (c) (*paragraph obsolete*).

O.C. 1472-92, s. 1.

8.0.3. The health insurance card may also omit the insured person's photograph and signature where he furnishes to the Board a medical certificate attesting that he is affected by a disease or a physical deficiency preventing him from furnishing a photograph to the Board or significantly limiting his ability to affix his signature.

O.C. 1472-92, s. 1.

8.0.4. In cases where a medical certificate is required under sections 8.0.2 and 8.0.3, the physician must indicate on the certificate the nature of the insured person's disease or physical deficiency and the duration of his incapacity.

O.C. 1472-92, s. 1.

8.1. The costs exigible for the replacement of a health insurance card before its expiry date shall amount to \$25 for a replacement in person or by mail and to \$15 for a replacement online.

O.C. 859-90, s. 1; O.C. 553-2001, s. 4; O.C. 78-2012, s. 1; O.C. 168-2013, s. 1; O.C. 957-2014, s. 1.

8.2. The following persons may obtain the replacement of their health insurance card free of charge:

- (a) persons who are 65 years of age or older;

(b) persons receiving benefits under a last resort financial assistance program provided for in the Individual and Family Assistance Act (chapter A-13.1.1).

O.C. 859-90, s. 1; O.C. 553-2001, s. 5.

8.3. The costs exigible for an application to renew the registration of an insured person who has not renewed his registration with the Board within 6 months after the card expires are \$25.

O.C. 553-2001, s. 6; O.C. 78-2012, s. 2; O.C. 168-2013, s. 2; O.C. 957-2014, s. 2.

8.4. The costs exigible for having a photo taken by the Régie amount to \$9.

O.C. 78-2012, s. 3.

DIVISION IV

STATEMENTS OF FEES, REQUESTS FOR PAYMENT AND MANDATES

R.R.Q., 1981, c. A-29, r. 2, Div. IV; Decision 81-12-07, s. 2.

9. Professionals in the field of health: Subject to section 9.4.1, every professional entitled to remuneration by the Board on a fee-for-service basis for insured services must transmit to the Board a statement of fees according to the form and tenor of Form 3 (physicians remunerated per consultation), 4 (dentists) or 5 (optometrists), as the case may be.

R.R.Q., 1981, c. A-29, r. 2, s. 9; Decision 81-12-07, s. 2; O.C. 794-84, s. 3; O.C. 1756-92, s. 1; O.C. 1116-93, s. 1; O.C. 400-2017, s. 1.

9.1. Every pharmacist entitled to remuneration by the Board for insured services must transmit to the Board a claim for payment or a statement of fees containing the following elements:

- (1) a control number identifying each claim for payment or each statement of fees submitted to the Board;
- (2) the insured person's health insurance number and the sequential number of his health insurance card or, where applicable, his name at birth, date of birth and sex;
- (3) where applicable, the insured person's relationship to the health insurance card holder;
- (4) where applicable, the code of the program to which the claim for payment or statement of fees is related;
- (5) where applicable, the code identifying a specific group of insured persons;
- (6) the pharmacy number;
- (7) the dispensing pharmacist's number;
- (8) the prescriber type, the prescriber number and, where applicable, the initials of his first and last names;
- (9) where applicable, the number of the designated pharmacy contacted;
- (10) the prescription number, the service code and, where applicable, the intervention or exception code describing a specific situation or service;
- (11) where applicable, an indication that the prescription is a new prescription or a refill, the code indicating whether the prescription is a written or a verbal prescription, the number of

authorized refills, the last date on which the prescription is valid, and the duration of the treatment;

(12) where applicable, the medication code or supplier code, an indication to the effect that the pharmacist has dispensed an equivalent medication or that the prescriber has indicated not to substitute, the quantity dispensed, the source of supply, the acquisition format number, and the type of magistral medication;

(13) the date of dispensation of the professional service;

(14) the amount of the fees claimed, by type of service, and, where applicable, the amount charged for the medication or service;

(15) where applicable, the transaction date of the cancelled claim for payment or cancelled statement of fees, and its control number;

(16) the signature of the pharmacist covered by the agreement or the signature of his duly authorized mandatary or his identification code where the statement of fees or claim for payment is transmitted by interactive electronic means.

O.C. 1756-92, s. 2; O.C. 1522-96, s. 1.

9.2. A physician or a dentist entitled to remuneration for insured services by the Board by way of fixed fees or salary, as the case may be, must transmit to the Board a statement of fees that must contain the following elements:

(1) a preprinted external control number identifying each statement of fees submitted to the Board;

(2) the full name of the physician or the dentist, as the case may be, and the number attributed to him by the Board;

(3) the name and numerical code of the establishment or centre, as the case may be, where the physician or the dentist has furnished the service for which he is submitting the statement of fees;

(4) the period covering the week during which the service was furnished, indicating the dates of the first and last day of the week in question;

(5) additional information needed by the Board to evaluate the statement of fees pursuant to section 68 of the Act;

(6) under the heading "SC", the codes for special cases or special consideration needed by the Board to evaluate the statement of fees pursuant to section 68 of the Act;

(7) an indication of the number of documents the physician or the dentist has attached to the form he is submitting;

(8) the information required respecting any service for which a statement of fees is submitted to the Board,

(a) indicating, for each day in question, the date or, as the case may be, the day of the month for the week in question, a mark designating the alphabetical code representing the work shift in question and, for each mark, the code for the main professional activity and, where applicable, the code for the location where the main professional activity took place, as well as the number of remunerable hours worked;

(b) the total number of hours worked as declared under subparagraph a;

(c) where applicable, from among the number of hours declared under subparagraph b, the number of overtime hours of professional activity for which a general practitioner or a dentist,

as the case may be, requests to be credited so that he may claim them at a later date;

(d) where applicable, indicating, for each day in question, the day of the month for the week in question, the duration of a leave, in days and half days, where such is the case, to which the physician or the dentist is entitled under the agreement binding him and which he has not taken, and the code of the leave, insofar as it is not part of a continuous or extended leave as declared in paragraph 11;

(e) the total number of days of leave, expressed in days and half days, where applicable, as declared under subparagraph d;

(9) where applicable, indicating the particular day of the month for the week in question, the number of hours of the same type as contemplated in subparagraph c of paragraph 8, accumulated prior to the week in question, which a general practitioner or a dentist, as the case may be, has used because they were credited in accordance with the provisions of the agreement binding him;

(10) the total number of hours declared under paragraph 9;

(11) for each period of continuous or extended leave beginning with the week in question, the code and duration, expressed in days and half days, where such is the case, of a leave to which the physician or the dentist is entitled under the agreement binding him and which he has taken, as well as the dates of the first and last day of the period of continuous or extended leave in question;

(12) reference codes that locate on the form the information provided by the physician or the dentist pertaining to the activities declared under subparagraph a, c or d of paragraph 8 or paragraphs 9 and 11;

(13) the amount of the benefits which a physician or a dentist already receives from a public retirement plan administered by Retraite Québec, from a social security plan administered by the Commission des normes, de l'équité, de la santé et de la sécurité du travail, Retraite Québec, the Société de l'assurance automobile du Québec or from any other plan to which the establishment or the Board has contributed;

(14) any remuneration received during a leave taken by the physician or the dentist to serve as juror or witness;

(15) the signature of the physician or the dentist, as the case may be, or that of his duly authorized mandatary, as well as the date of the signature;

(16) the signature of a person who is duly authorized by the establishment where the physician or the dentist furnished the service for which he is submitting a statement of fees, as well as the date of the signature.

In addition, where the service is furnished to the following persons:

(a) an insured person who has not presented his health insurance card;

(b) an insured person to whom a service is furnished within the scope of the Workmen's Compensation Act (chapter A-3), the Act respecting industrial accidents and occupational diseases (chapter A-3.001), the Crime Victims Compensation Act (chapter I-6), the Act to promote good citizenship (chapter C-20) or as a result of an accident other than an industrial accident;

(c) an insured person who received an uninsured service;

(d) a person who is not an insured person;

(e) an insured person who holds a valid claim booklet where the service is furnished by a dentist;

the statement of fees must also contain, for each mark designating the alphabetical code representing the work shift in question for each day in question and for each person in question, the following elements:

- (1) the insured person's health insurance number, the year and month of expiry of the insured person's health insurance card and the serial number of the card or, if not available, the person's full name at birth, date of birth, sex and address including, where available, the postal code;
- (2) the diagnosis or the diagnostic code;
- (3) the procedural code or, if not available, the time devoted to the professional activity, in 15-minute segments;
- (4) an indication that the service is furnished within the scope of the Workmen's Compensation Act or the Act respecting industrial accidents and occupational diseases, and the date of the accident or the event, that the service is furnished as a result of an accident other than an industrial accident, or that the service is furnished to an insured person who is not insured or to a person who is not an insured person or did not present a health insurance card;
- (5) an indication that the service is furnished within the scope of the Crime Victims Compensation Act or the Act to promote good citizenship and the date of the event;
- (6) an indication by the dentist that the insured person holds a valid claim booklet, or that he holds one but did not present it, as well as a reference to the surface and tooth treated, where applicable.

This form may also contain the name of the spouse in the case of a married female insured person, where such name appears on the health insurance card. The form may contain spaces reserved for the use of the Board.

The elements provided for in subparagraphs 1 to 6 of the second paragraph are not required on the statement of fees where the insured service is furnished to an insured person who has not presented his health insurance card, in the following circumstances and cases:

- (1) where the insured person is under 1 year of age;
- (2) where the service is furnished within the scope of the Workmen's Compensation Act, the Act respecting industrial accidents and occupational diseases, the Act to promote good citizenship, the Crime Victims Compensation Act, the Act respecting assistance and compensation for victims of crime (1993, chapter 54) or as a result of an accident other than an industrial accident:
 - (a) where the insured person needs psychiatric services or services furnished within the scope of an intervention plan developed by the institution for that insured person, and the institution operating the centre in which those services are furnished has the health insurance number and the date of expiry of the insured person's health insurance card, provided that the validity period of the card has not expired;
 - (b) where the insured person, at the time he receives the insured service, is in a condition requiring emergency care;
 - (c) *(subparagraph implicitly revoked; 1992, chapter 57, s. 659);*
 - (d) where the insured person is lodged by an institution operating a residential and long-term care centre or a rehabilitation centre within the meaning of the Act respecting health services and social services (chapter S-4.2) or where he is sheltered in a reception centre or a hospital centre belonging to the class of hospital centres for long-term care within the meaning of the Act respecting health services and social services for Cree Native persons (chapter S-5) and the regulations made under that Act;

(e) where the insured person receives an insured service furnished by a physician within the framework of the medical emergency intervention service of the Montréal-Métropolitain region or of the aeromedical evacuation system in Québec;

(f) where the insured person resides and receives the insured service in a locality or in a territory that is not organized as a locality and that is located north of the 55th parallel.

O.C. 1116-93, s. 2; O.C. 1040-94, s. 1.

9.3. A physician or a dentist entitled to remuneration for insured services by the Board by way of fees for a fixed price or fees must transmit to the Board a statement of fees that must contain the following elements:

(1) a preprinted external control number identifying each statement of fees submitted to the Board;

(2) the full name of the physician or the dentist, as the case may be, the group number, if any, and the number attributed to him by the Board;

(3) the name and numerical code of the establishment or centre, as the case may be, where the physician or the dentist has furnished the service for which he is submitting the statement of fees;

(4) the period covering the week during which the service was furnished, indicating the dates of the first and last day of the week in question;

(5) additional information needed by the Board to evaluate the statement of fees pursuant to section 68 of the Act;

(6) under the heading "SC", the codes for special cases or special consideration needed by the Board to evaluate the statement of fees pursuant to section 68 of the Act;

(7) an indication of the number of documents the physician or the dentist has attached to the form he is submitting;

(8) the information required respecting any service for which a statement of fees is submitted to the Board,

(a) indicating, for each day in question, the date or, as the case may be, the day of the month for the week in question, a mark designating the alphabetical code representing the work shift in question and, for each mark, the code for the mode of remuneration according to which the physician or the dentist requests payment, the code for the main professional activity and, where applicable, the code for the location where the main professional activity took place, as well as the number of remunerable hours worked;

(b) the total number of hours worked as declared under subparagraph a;

(9) reference codes that locate on the form the information provided by the physician or the dentist pertaining to the professional activities declared under subparagraph a of paragraph 8;

(10) where applicable, travel expenses for the distance in kilometres which the physician or the dentist, as the case may be, claims for reimbursement:

(11) information regarding travel expenses for the distance in kilometres for which he is requesting reimbursement: the location of the establishment or, as the case may be, the centre in which the physician or the dentist usually carries out the professional activity, the location of the establishment or, as the case may be, the centre visited, the date and time of his arrival, the total distance travelled in kilometres that he may claim under the agreement binding him, the travel time, in hours and minutes, for the return trip in a case where the physician or dentist is filling in for another physician or dentist;

(12) the signature of the physician or the dentist, as the case may be, or that of his duly authorized mandatary, as well as the date of the signature;

(13) the signature of a person who is duly authorized by the establishment where the physician or the dentist furnished the service for which he is submitting a statement of fees, as well as the date of the signature.

In addition, where the service is furnished to the following persons:

(a) an insured person who has not presented his health insurance card;

(b) an insured person to whom a service is furnished within the scope of the Workmen's Compensation Act (chapter A-3), the Act respecting industrial accidents and occupational diseases (chapter A-3.001), the Crime Victims Compensation Act (chapter I-6), the Act to promote good citizenship (chapter C-20) or as a result of an accident other than an industrial accident;

(c) an insured person who received an uninsured service;

(d) a person who is not an insured person;

(e) an insured person who holds a valid claim booklet where the service is furnished by a dentist;

the statement of fees must also contain, for each mark designating the alphabetical code representing the work shift in question for each day in question and for each person in question, the following elements:

(1) the insured person's health insurance number, the year and month of expiry of the insured person's health insurance card and the serial number of the card or, if not available, the person's full name at birth, date of birth, sex and address including, where available, the postal code;

(2) the diagnosis or the diagnostic code;

(3) the procedural code or, if not available, the time devoted to the professional activity, in 15-minute segments;

(4) an indication that the service is furnished within the scope of the Workmen's Compensation Act or the Act respecting industrial accidents and occupational diseases, including the date of the accident or the event, that the service is furnished as a result of an accident other than an industrial accident, or that the service is furnished to an insured person who is not insured or to a person who is not an insured person or did not present a health insurance card;

(5) an indication that the service is furnished within the scope of the Crime Victims Compensation Act or the Act to promote good citizenship and the date of the event;

(6) an indication by the dentist that the insured person holds a valid claim booklet, or that he holds one but did not present it, as well as a reference to the surface and tooth treated, where applicable.

This form may contain the name of the spouse in the case of a married female insured person, where such name appears on the health insurance card. The form may also contain spaces reserved for the use of the Board.

The elements provided for in subparagraphs 1 to 6 of the second paragraph are not required on the statement of fees where the insured service is furnished to an insured person who has not presented his health insurance card, in the following circumstances and cases:

(1) where the insured person is under 1 year of age;

(2) where the service is furnished within the scope of the Workmen's Compensation Act, the Act respecting industrial accidents and occupational diseases, the Act to promote good citizenship, the Crime Victims Compensation Act, the Act respecting assistance and compensation for victims of crime (1993, chapter 54) or as a result of an accident other than an industrial accident:

(a) where the insured person needs psychiatric services or services furnished within the scope of an intervention plan developed by the institution for that insured person, and the institution operating the centre in which those services are furnished has the health insurance number and the date of expiry of the insured person's health insurance card, provided that the validity period of the card has not expired;

(b) where the insured person, at the time he receives the insured service, is in a condition requiring emergency care;

(c) *(subparagraph implicitly revoked; 1992, chapter 57, s. 659);*

(d) where the insured person is lodged by an institution operating a residential and long-term care centre or a rehabilitation centre within the meaning of the Act respecting health services and social services (chapter S-4.2), or where he is sheltered in a reception centre or a hospital centre belonging to the class of hospital centres for long-term care within the meaning of the Act respecting health services and social services for Cree Native persons (chapter S-5) and the regulations made under that Act;

(e) where the insured person receives an insured service furnished by a physician within the framework of the medical emergency intervention service of the Montréal-Métropolitain region or of the aeromedical evacuation system in Québec;

(f) where the insured person resides and receives the insured service in a locality or in a territory that is not organized as a locality and that is located north of the 55th parallel.

O.C. 1116-93, s. 3; O.C. 1040-94, s. 2.

9.4. Subject to section 9.4.1, every health professional who is entitled to remuneration by the Board for insured services may submit to the Board his claim for payment or his statement of fees by means of either of the following billing systems:

(1) an electronic data processing or telecommunication system; or

(2) a printed form.

O.C. 1218-95, s. 1; O.C. 400-2017, s. 1.

9.4.1. The statement of fees or claim for payment from a health professional must be transmitted to the Board solely by electronic means for the following classes of professionals and for the method of remuneration indicated:

(a) general practitioners and medical specialists, for the method of remuneration by the act;

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(b) dentists and optometrists, for the method of remuneration by the act.

O.C. 400-2017, s. 2.

9.5. *(Revoked).*

O.C. 1218-95, s. 1; O.C. 1335-98, s. 1; O.C. 400-2017, s. 3.

9.6. *(Revoked).*

O.C. 1218-95, s. 1; O.C. 1335-98, s. 2; O.C. 400-2017, s. 3.

9.7. *(Revoked).*

O.C. 1218-95, s. 1; O.C. 400-2017, s. 3.

10. (1) Mandate respecting the signing of statements of fees, claims and any related document:

Every professional in the field of health must sign his statements of fees or claims and any document related thereto to certify that he personally provided the services listed on his statements of fees or claims; a pharmacist who has not personally provided the services listed on his claims and any related document must certify that such services were provided legally by one of his employees.

A professional in the field of health may authorize one or more mandataries, in accordance with the form and tenor of Form 6, to sign, on his behalf and in his name, his statements of fees or claims and any related document, including any notice of change of address, to certify that the services listed on any statement of fees or claim and on any related document were provided by the mandator himself, to receive from the Board any information he may require respecting the statements of fees or claims he is hereby authorized to sign. In the case of a pharmacist who did not personally provide the services listed on the claim or related documents, the mandatary shall be authorized to certify that such services were provided legally by an employee of the pharmacist.

(2) *(paragraph revoked);*

(3) *(paragraph revoked).*

R.R.Q., 1981, c. A-29, r. 2, s. 10; O.C. 553-87, s. 3; O.C. 1335-98, s. 3.

11. Request for payment or reimbursement by an insured person

(1) **For services received outside Québec:** Every insured person who exacts reimbursement by the Board of the cost of insured services furnished to him outside Québec from a professional in the field of health or who requests the Board to assume on his behalf the payment of the cost of services, must transmit to the Board:

(a) in the case of an application for reimbursement, the originals of the receipts of the fees paid by him and provide the information required by the Board to justify the reimbursement claimed; or

(b) in the case of a claim, the originals of the statements of account and provide the information required by the Board to justify the payment claimed.

The originals of receipts of fees and of statements of account must be duly signed by every health professional who rendered the insured services.

(2) **For services obtained from a professional who has withdrawn:** Every insured person who exacts from the Board payment of the cost of the insured services furnished to him in Québec by a professional who has withdrawn, must send to the Board a request for payment form duly signed and completed by the professional according to the form and tenor of Forms 3 (physicians), 4 (dentists) or 5 (optometrists).

(3) *(paragraph revoked);*

(4) **For services obtained in Québec from a professional subject to the application of an agreement, by an insured person who has not presented his health insurance card or his claim booklet, as the case may be:** Every insured person who has not presented his health insurance card or his claim booklet, as the case may be, and who exacts from the Board payment or reimbursement of the cost of the insured services furnished to him in Québec by a professional subject to the application of an agreement, must send to the Board a request for payment or reimbursement form duly completed and signed by the professional according to the form and tenor of Forms 26 (physicians), 27 (dentists) or 28 (optometrists).

(4.1) Every insured person who has not presented his health insurance card or claim booklet, as the case may be, every person who resides in Québec, as well as a person who is referred to in paragraph 4 of section 15 of the Act respecting prescription drug insurance (chapter A-29.01), who is not registered with the Board under section 19 of that Act and who requires that the Board reimburse him for the cost of insured services provided to him in Québec by a pharmacist covered by the agreement must send the Board an application for reimbursement containing the following information:

- (a) the elements provided for in section 9.1 in a section of the application reserved for the pharmacist;
- (b) in a section of the application reserved for the insured person, the address of the insured person's domicile and, if different, the address at which he wishes to receive the reimbursement;
- (c) an indication by the insured person to the effect that his health insurance card has expired, where such is the case;
- (d) an indication by the insured person to the effect that he has never applied for a health insurance card, where such is the case, or no longer has one, where such is the case; in the latter case, the date on which he notified the Board to that effect;
- (e) an indication by the insured person that he holds a health insurance card or a claim booklet, but that he presented neither of them, where such is the case;
- (f) an indication by the insured person that he has not yet received, where such is the case, a health insurance card that he applied for or for which he requested a replacement; in the latter 2 cases, the date of the application;
- (f.1) an indication by the insured person to the effect that he is not registered for the prescription drug insurance plan;
- (g) the insured person's signature and the date on which he signed.

The insured person's application for reimbursement must also contain the following mention above the space reserved for the insured person's signature:

"I certify that the above information is accurate and I request a reimbursement for the cost of the services received".

(5) *(paragraph revoked)*.

R.R.Q., 1981, c. A-29, r. 2, s. 11; O.C. 1471-92, s. 5; O.C. 1756-92, s. 3; O.C. 1522-96, s. 2; O.C. 1089-2011, s. 1.

DIVISION V

(Revoked)

R.R.Q., 1981, c. A-29, r. 2, Div. V; O.C. 1471-92, s. 6.

12. *(Revoked)*.

R.R.Q., 1981, c. A-29, r. 2, s. 12; Decision 81-12-07, s. 2; O.C. 1471-92, s. 6.

DIVISION VI

CLAIM BOOKLET

13. Every person eligible for benefits under a last resort assistance program under the Individual and Family Assistance Act (chapter A-13.1.1) or who receives the monthly

guaranteed income supplement in accordance with the Old Age Security Act (R.S.C. 1985, c. O-9), must be the holder of a claim booklet in force, issued under section 70 of the Health Insurance Act (chapter A-29) and in conformity with the form and tenor of Form 15.

Every person at least 60 years of age and less than 65 years of age:

- (a) who receives an allowance under Part II.1 of the Old Age Security Act; and
- (b) who would but for such allowance be eligible for benefits under a last resort assistance program under the Individual and Family Assistance Act,

must hold a claim booklet attesting that he is entitled to the services mentioned in the fourth paragraph of section 3 of the Health Insurance Act, during the period provided in the booklet. The said booklet shall be issued in accordance with section 71 of the said Act in Form 15.

R.R.Q., 1981, c. A-29, r. 2, s. 13.

DIVISION VII

APPLICATION FOR AUTHORIZATION

R.R.Q., 1981, c. A-29, r. 2, Div. VII; O.C. 2284-83, s. 1.

14. (Revoked).

R.R.Q., 1981, c. A-29, r. 2, s. 14; O.C. 2284-83, s. 1; O.C. 1471-92, s. 7; O.C. 1089-2011, s. 2.

DIVISION VIII

BILLING BY MAGNETIC RECORDING AND TELECOMMUNICATIONS

R.R.Q., 1981, c. A-29, r. 2, Div. VIII; O.C. 413-85, s. 2.

15. Application for accreditation: A professional in the field of health, or a group of professionals in the field of health duly constituted under Form 7 wishing to submit his statements of fees or claims to the Board by means of magnetic recording media or telecommunications must, beforehand, send the Board a duly completed application for accreditation drawn up as in Form 22.

The Board shall consider each application for accreditation and send its decision to the applicant in writing. An application for accreditation shall be accepted if the applicant meets the requirements of sections 16 and 18.

Where an application for accreditation is submitted to the Board by a group of professionals in the field of health and where the Board accepts the application, each of the professionals in the field of health who is a member of the accredited group is deemed to be an accredited professional in the field of health and all of the provisions of Division VIII apply to him with the necessary modifications.

R.R.Q., 1981, c. A-29, r. 2, s. 15; O.C. 413-85, s. 3; O.C. 1178-86, s. 2; O.C. 553-87, s. 4.

15.0.1. This Division does not apply to a pharmacist in respect of a service rendered after 1 January 1997.

O.C. 1522-96, s. 3.

16. Mandate: A professional in the field of health, or any member of a group of professionals in the field of health duly constituted under Form 7 wishing to authorize a data processing agency to claim his fees from the Board on his behalf as his mandatary, must attach to his application for accreditation a duly completed mandate drawn up as in Form 23.

R.R.Q., 1981, c. A-29, r. 2, s. 16; O.C. 553-87, s. 4.

17. Cases and conditions in which a data processing agency may act as mandatary: A data processing agency may claim fees from the Board as the mandatary of an accredited professional or a member of an accredited group of professionals where the agency:

- (a) is duly authorized for this purpose by the accredited professional or the member of the accredited group of professionals;
- (b) satisfies all of the conditions set out in sections 23 and 29;
- (c) is remunerated for its services other than on the basis of a commission or a percentage of the amount of fees payable or paid by the Board; and
- (d) complies with section 28.1.

R.R.Q., 1981, c. A-29, r. 2, s. 17; O.C. 2331-85, s. 1; O.C. 553-87, s. 4.

18. Documents to be submitted with an application for accreditation: A professional in the field of health or a group of professionals in the field of health submitting an application for accreditation must provide the Board with a detailed description of the billing and auditing system used, which must comply with the technical specifications established by the Board and published in the manual.

A group of professionals in the field of health, constituted under Form 7 must attach to its application for accreditation a duly completed copy of the group form and, where applicable, a copy of Form 6 authorizing a mandatary to sign the billing statements of members of the group.

R.R.Q., 1981, c. A-29, r. 2, s. 18; O.C. 553-87, s. 4.

19. Billing statement: On providing an insured service, an accredited professional must always record in a duly completed billing statement the information required under section 31 and sign the document himself.

Where an accredited professional or an accredited group of professionals sends the same information to a data processing agency by means of a telecommunication system or terminals, or where the professional or the group itself processes the same information by means of computerized equipment or material, and the billing statement is processed by means of computerized equipment or material, the accredited professional or the professional who is a member of the accredited group must sign the billing statement himself. His signature must be affixed to the last page of a continuous format multiple page document or on each page in every other case.

For a accredited group of professionals, a mandatary duly authorized in accordance with Form 6 may sign the billing statement as prescribed on behalf of a professional who is a member of the group.

R.R.Q., 1981, c. A-29, r. 2, s. 19; O.C. 1178-86, s. 3; O.C. 553-87, s. 4; O.C. 1522-96, s. 4.

20. Keeping of billing statements: An accredited professional or an accredited group of professionals must keep the billing statement for a 5-year period from the date on which the insured service was provided. He must ensure that the statement is available for auditing and inspection by any person authorized by the Board. He must send a copy thereof of the Board upon request.

In the case of an accredited group of professionals, the first paragraph continues to apply with respect to the group for every professional who was accredited and who was no longer part

of the group at the time a person authorized by the Board carries out an audit or inspection or at the time the Board requests a copy thereof. If the group has given a professional leaving the group the billing statements that concern him, the professional must keep the billing statements as prescribed.

R.R.Q., 1981, c. A-29, r. 2, s. 20; O.C. 413-85, s. 4; O.C. 553-87, s. 4.

21. Contract with data processing agency: A professional in the field of health or a group of professionals, accredited or not, wishing to use the services of a data processing agency must, at the request of the Board, send the Board a copy of his contract with the agency, excluding any provisions respecting administrative costs.

R.R.Q., 1981, c. A-29, r. 2, s. 21; O.C. 553-87, s. 4.

22. Payment of fees due: The Board pays the fees due to the accredited professional or to a third party authorized in accordance with the Act, with this Regulation and with any agreements.

R.R.Q., 1981, c. A-29, r. 2, s. 22.

23. Confidential information: The data processing agency commits itself not to divulge any information or data respecting the papers relevant to the claims of an accredited professional, except to the Board.

R.R.Q., 1981, c. A-29, r. 2, s. 23.

24. Permission granted to Board: A professional in the field of health or an accredited group of professionals in the field of health must allow any person authorized by the Board to communicate with a data processing agency with which he deals or has dealt, and to examine any data and documents pertaining to a claim.

R.R.Q., 1981, c. A-29, r. 2, s. 24; O.C. 553-87, s. 5.

25. New application for accreditation: An accredited professional or an accredited group of professionals must, beforehand, submit a new application for accreditation of the Board where he:

- (a) alters his contract with a data processing agency;
- (b) changes agencies; or
- (c) changes the means of sending his data.

However, where an agency duly authorized by accredited professionals makes a decision of an administrative or technical nature that will change or alter the accreditation of one party or the aggregate of its mandators, the professionals in the field of health in question need not submit a new application for accreditation.

In the case covered by the second paragraph, the agency must so inform the Board in writing 30 days before applying the decision indicating to the Board the nature of the change and the names and professional numbers of the professionals in the field of health in question.

R.R.Q., 1981, c. A-29, r. 2, s. 25; O.C. 553-87, s. 5.

26. Notice of end of accreditation: An accredited professional or an accredited group of professionals must notify the Board in writing 30 days before his contract with a data processing agency ends.

An accredited professional or an accredited group of professionals may cancel his accreditation by giving 30 days' prior notice in writing.

An accredited professional or an accredited group of professionals retains his accreditation with the Board in so far as he complies with the requirements of this Division.

Where the Board finds that billing submitted by magnetic recording media or telecommunications does not comply with the requirements of this Division, it shall notify the accredited professional or the accredited group of professionals in writing. He must comply with the provisions he has contravened, as set out in the notice, within 15 days, failing which his accreditation shall cease at the expiry of that period.

Notwithstanding the fourth paragraph, where the Board finds that the accredited professional or accredited group of professionals uses the mathematical algorithms and other validation procedures for purposes other than those provided for in section 28.1, it will immediately cancel, by notice in writing, the accreditation of the professional or group in question.

R.R.Q., 1981, c. A-29, r. 2, s. 26; O.C. 413-85, s. 5; O.C. 2331-85, s. 2; O.C. 553-87, s. 5.

27. Billing statements processed by data processing agency: A billing statement processed by a data processing agency, whether produced manually or by computer equipment or hardware, must contain all of the information required under section 31.

R.R.Q., 1981, c. A-29, r. 2, s. 27; O.C. 1178-86, s. 4; O.C. 553-87, s. 5; O.C. 1522-96, s. 5.

28. Information sent to the Board by magnetic recording media or telecommunications: Information sent to the Board by magnetic recording media or telecommunications must be identical to that in the billing statement, except for the signature of the accredited professional or his duly authorized mandatary, as the case may be.

R.R.Q., 1981, c. A-29, r. 2, s. 28; O.C. 413-85, s. 6; O.C. 1178-86, s. 5; O.C. 553-87, s. 5.

28.1. Mathematical algorithms and other validation procedures: The Board may, at the request of an accredited professional, an accredited group of professionals or a data processing agency acting as the mandatary of the professional or group, send him the mathematical algorithms and other validation procedures it uses to validate the information received from the professional, the group or the data processing agency.

An accredited professional or accredited group of professionals obtaining such information from the Board, or the data processing agency acting as the mandatary of the professional or group, may use such information solely to validate the information to be sent to the Board by magnetic recording media or telecommunications.

A data processing agency obtaining such information from one of its mandators may use it to validate the information it sends to the Board on behalf of all of its mandators.

O.C. 2331-85, s. 3; O.C. 1178-86, s. 6; O.C. 553-87, s. 5.

29. Manual: The magnetic recording media by which data is sent to the Board must comply with the technical specifications established by the Board and published in the manual.

The sending of data to the Board by telecommunications must comply with the technical specifications established by the Board and published in the manual.

The accredited professional, the accredited group or their mandatary, as the case may be, must keep a duplicate of the magnetic recording sent to the Board until the Board has returned the original.

The accredited professional, the accredited group or their mandatary, as the case may be, must keep a duplicate corroborating the sending of data by telecommunications until the Board notifies him or them that the data has been received.

R.R.Q., 1981, c. A-29, r. 2, s. 29; O.C. 413-85, s. 6; Erratum, 1985 G.O. 2, 1635 and 1679; O.C. 553-87, s. 5.

30. (Revoked).

R.R.Q., 1981, c. A-29, r. 2, s. 30; O.C. 1178-86, s. 7.

31. Billing statement — physicians, dentists and optometrists: For physicians, dentists and optometrists, the billing statement produced manually or by computer equipment or hardware, must contain the following information:

(a) in accordance with technical specifications in the manual, a reference number for the sending of information forwarded to the Board by means of magnetic recording media or by telecommunication, which must appear on each page;

(a.1) in accordance with technical specifications in the manual, an external check number identifying each statement of fees or request for payment, as the case may be;

(b) the insured person's Health Insurance Number or, if not available, his given name and surname at birth, date of birth and sex;

(c) the number and, if applicable, the group number of the accredited professional;

(d) the number or, if not available, the initial and surname of the health professional who requested a consultation or other insured services from the health professional submitting the claim;

(e) the diagnosis and an indication of any service rendered within the framework of legislation administered by the Commission des normes, de l'équité, de la santé et de la sécurité du travail;

(e.1) where the service was rendered within the framework of legislation administered by the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the date on which the occupational injury or occurrence took place;

(f) any information required by the Board to evaluate services claimed, such as roles, modifiers, units;

(g) the number of the institution, if applicable, or, where services were provided by a physician outside an institution, the number of the locality based on the codes assigned by the Board;

(h) the date of the insured person's admission to an institution and the date of discharge, if applicable;

(i) the date on which the service was rendered;

(j) the code of the procedure claimed and the relevant fees;

(k) the number of kilometers and the amount reimbursable under the agreement;

(l) all fees demanded;

(m) the signature of the accredited professional or of the duly authorized mandatary, as the case may be.

Notwithstanding the foregoing, for physicians and dentists remunerated by way of fixed fees or salary, and for physicians and dentists remunerated by way of fees for a fixed price of fees,

the billing statement produced manually or by computer equipment or hardware must contain the signature of the physician or dentist, as the case may be, or the signature of his duly authorized mandatary, in addition to the signature of the person duly authorized by the institution at which the professional provided the service for which he is submitting the statement of fees, as well as, if they are forwarded, the elements referred to in section 9.2 or 9.3, as the case may be, and the following elements:

in accordance with the technical specifications in the computerized billing instructions forwarded to the physician or dentist, the data corresponding to the following identification or forwarding coordinates:

- (1) a reference number for the sending of information forwarded to the Board by means of magnetic recording media or telecommunications media, which must appear on each page;
- (2) the number of the data processing agency, where applicable;
- (3) the system code and the record code used for forwarding data;
- (4) the attestation number for the consignment of requests for payment;
- (5) indications of the beginning and end of the forwarding of data.

R.R.Q., 1981, c. A-29, r. 2, s. 31; O.C. 413-85, s. 7; O.C. 655-86, s. 1; O.C. 1178-86, s. 8; O.C. 553-87, s. 6; O.C. 1289-96, s. 1.

32. (Revoked).

R.R.Q., 1981, c. A-29, r. 2, s. 32; O.C. 413-85, s. 7; O.C. 1178-86, s. 9; O.C. 553-87, s. 7; O.C. 1756-92, s. 4; O.C. 1522-96, s. 6.

33. Codes of reference: An accredited professional or an accredited group of professionals may complete the billing statement by using codes of reference, provided he submits a list of the codes and their meanings to the Board for approval beforehand.

R.R.Q., 1981, c. A-29, r. 2, s. 33; O.C. 553-87, s. 8.

DIVISION IX

APPLICATION FOR AUTHORIZATION — SPECIAL MEDICATIONS

O.C. 1126-82, s. 2.

34. Any insured person who is entitled to insured medications and who wishes the Board to assume the cost of special medications determined by regulation must send to the Board a duly completed application for authorization in accordance with the form and tenor of Form 31. However, such a form may be sent to the Board by a physician or dentist on behalf of an insured person.

O.C. 1126-82, s. 2; O.C. 1471-92, s. 8.

SCHEDULE I

(s. 8.0.1)

LIST OF LOCATIONS WHERE INSURED PERSONS ARE EXEMPTED FROM PROVIDING A PHOTOGRAPH AND SIGNING THE HEALTH INSURANCE CARD

Aguanish

Akulivik

Aupaluk
Aylmer Sound
Baie-des-Moutons
Baie-d'Hudson
Baie-Johan-Beetz
Blanc-Sablon
Brador
Chevery
Chisasibi
Clova
Eastmain 1
Eastmain
Étamamiou
Grand-Lac-Victoria
Harrington Harbour
Île Michon
Inukjuak
Ivujivik
Kangiqsualujjuaq
Kangiqsujaq
Kangirsuk
Kawawachikamach
Kegaska
Kuujjuaq
Kuujuarapik
La Romaine
La Tabatière
Lourdes-de-Blanc-Sablon
Manouane
Matimekosh
Middle Bay
Mistissini

Musquaro
Natashquan
Nemiscau
Obedjiwan
Pakuashipi
Parent
Port-Menier
Povungnituk
Quaqtaq
Salluit
Schefferville
Saint-Augustin du Saguenay
Saint-Paul du Saguenay
Tasiujaq
Tête-à-la-Baleine
Umiujaq
Vieux-Fort
Waskaganish
Waswanipi
Wemindji
Weymontachie
Whapmagoostui
Wolf Bay

O.C. 68-94, s. 3.

FORMS 1 TO 31

(Please contact the Régie de l'assurance maladie du Québec.)

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O.C. 56-82, 1982 G.O. 2, 613; Suppl. 123
O.C. 1126-82, 1982 G.O. 2, 1767; Suppl. 126
O.C. 3017-82, 1982 G.O. 2, 79
O.C. 2284-83, 1983 G.O. 2, 4051
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O.C. 2331-85, 1985 G.O. 2, 4120
O.C. 655-86, 1986 G.O. 2, 894
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