

PHARMACY CLAIM SUBMISSION FORM

SECTION 1 PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER	CONTACT PERSON'S NAME
NAME OF PHARMACY		
ADDRESS		
CITY	PROVINCE	POSTAL CODE

SECTION 2 – MANUAL CLAIM SUBMISSION

CERTIFICATE NUMBER	SURNAME	FIRST NAME	DISPENSING DATE			DIN	NO SUB (1 OR 2)	QTY	RX NUMBER	DAY SUPPLY	COST	FEE	SS FEE / COB AMT	INTER-VENTION CODE	GROSS AMOUNT
			Y	M	D										

SECTION 3 – COMPOUND CLAIM SUBMISSION

CERTIFICATE NUMBER	SURNAME	FIRST NAME	COMPOUND CODE	QTY	DAYS SUPPLY	RX NUMBER	DISPENSING DATE			GROSS AMOUNT	PROF. FEE
							YEAR	MONTH	DAY		
										COMPOUND TIME	
INGREDIENTS					DIN	QUANTITY	COST		CHARGE PER MINUTE		
										TOTAL \$	
										<u>NAME OF PHYSICIAN</u>	
										TOTAL COST	

SECTION 4 – AUTHORIZATION

I HEREBY CERTIFY THAT THE DRUGS CLAIMED HEREON HAVE BEEN PROVIDED TO THE PERSON(S) IDENTIFIED ABOVE

SIGNATURE OF PHARMACIST

DATE

SECTION 5 – MAILING INSTRUCTIONS

PLEASE RETAIN COPIES FOR YOUR FILES AS CORRESPONDENCE PROVIDED WILL NOT BE RETURNED
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE

PLEASE INDICATE ON MAILING ENVELOPE:

SSQ Health Insurance Claims
P.O. BOX 10500, Strn Sainte-Foy, Quebec City, QC
G1V 4H6

CUSTOMER SERVICE CENTRE 1-800-463-6262 FAX 1-855-453-3942
SSQ.CA