PHARMACY PROVIDER ACQUISITION COST REQUEST FORM

SECTION 1 – PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER

NAME OF PHARMACY

ADDRESS

CITY | PROVINCE | POSTAL CODE

SECTION 2 – CLAIM DETAILS

SSQ CERTIFICATE NUMBER	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	RX NUMBER	NAME OF DRUG	QTY	GROSS AMOUNT (COST + FEE)

ATTENTION PHARMACY:

YOU MUST COMPLETE THIS FORM BEFORE ANY ACQUISITION COST REQUEST WILL BE CONSIDERED. BEFORE COMPLETING THIS FORM AND SUBMITTING YOUR REQUEST, PLEASE REVIEW THE FOLLOWING INFORMATION ON OUR DRUG CLAIM SUBMISSION REIMBURSEMENT TO ENSURE YOUR REQUEST IS APPLICABLE.

You must submit a copy of your invoice to substantiate your request.

SECTION 3 – AUTHORIZATION

SIGNATURE OF PHARMACIST

Y M D

DATE

SECTION 4 – 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 (unless otherwise stated in benefit plan documentation).

PLEASE INDICATE ON ENVELOPE:

SSQ Health Insurance Claims
P.O. Box 10500, Stn Sainte-Foy, Québec City, QC
G1V 4H6

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