CLAIM REVERSAL REQUEST

SSQ
P.O. Box 10500, Stn Sainte-Foy, Quebec City, QC G1V 4H6
1-800-463-6262 Fax: 1 855 453-3942

Benefit Type:

- ☐ Drug
- ☐ Medical Items
- ☐ Vision Care
- ☐ Dental
- ☐ Professional Services
- ☐ Hospital Accommodation
- ☐ Audio
- ☐ _____

Provider Name:	Provider Number:
Patient Name:	SSQ Certificate Number
Date of Service:	Form I.D. **#** (Internal Use Only):
Procedure Code / DIN:	Rx #:
Description of Product/Service:	
Claim Paid Amount:	Payee Type: ☐ Provider ☐ Plan Member

Have you received a cheque?

☐ No

☐ Yes If yes, what is the status of the cheque? ☐ Cashed ☐ Destroyed

Reversal Reason:

_____

_____

_____

_____

_____

☐ Please reprocess original claim with requested change.

Requested By:

_____ _____
Name of Authorized Individual (Please print) Telephone Number

_____ _____
Signature Date

By signing this claim form, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ will be used by SSQ for claims adjudication.

Please fax to: **SSQ**
1-855-453-3942