SSQ insurance

PHARMACY ADJUSTMENT FORM

SECTION 1 – PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER	CONTACT PERSON'S NAME

NAME OF PHARMACY

ADDRESS

CITY	PROVINCE	POSTAL CODE

REASON CODES FOR ADJUSTMENT

1 – PRODUCT SELECTION CODE MISSING – PLEASE INDICATE: 1 OR 2
2 – WRONG QUANTITY
3 – MULTIPLE SIZE (i.e.: 1ML, 5ML, 10ML – INDICATE PACKAGE SIZE DISPENSED)
4 – NO OF MONTHS SUPPLY
5 – CHANGE IN GROSS AMOUNT (COST + FEE)
6 – WRONG DIN USED
7 – RX CANCELLED OR NOT PICKED UP (DEBIT)

REASON: _____

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SECTION 2 – ADJUSTMENT INFORMATION

SSQ CERTIFICATE NUMBER	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	RX NUMBER	NAME OF DRUG	NO OF MTHS	1 OR 2	QTY	GROSS AMOUNT	(COST + FEE)	REASON CODE

_____
SIGNATURE OF PHARMACIST

Y M D
_____
DATE

SECTION 3 – 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 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