GEN 3
P-HCV$F-GN3/1

The 1986-1990 Hepatitis C Claims Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

Compensation for Uninsured Treatment/Medication and Out-of-Pocket Expenses
Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED
* If you do not have the labels, call 1 877 434-0944 for instruction

CORRECTIONS ONLY
Write any name, address or telephone number corrections below, if any corrections are necessary.

This form is to be completed by the HCV Infected Person or his or her Personal Representative.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	City/Municipality	Province/Territory	Postal Code

PERSONAL REPRESENTATIVE OF THE HCV INFECTED PERSON

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City/Municipality	Province/Territory	Postal Code

SECTION B – EXPENSES OUTSIDE OF CANADA

Were all expenses incurred in Canada? Yes ☐ No ☐

If **No,** please provide an explanation and list those expenses incurred **outside** of Canada.

DD/MM/YYYY	Description of Expense	Receipt Enclosed	Total Cost	Currency Type	Amount Reimbursed by Health Plan	Amount Claimed
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$
/ /		☐ Yes	$		$	$

SECTION C – OUT-OF-POCKET EXPENSES

Please list only expenses that you are claiming at this time. **Organize your claim before submitting**; list dates, provide description of expenses, costs, amount paid by Health Plan and amount claimed for each item.

Date DD/MM/YYYY	Out-of-Pocket-Expense Description	Receipt Enclosed	Total Cost	Amount Reimbursed by Health Plan	Amount Claimed
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$

SECTION D – UNINSURED TREATMENT/MEDICATION EXPENSES

Claim Number #________________________________

Please indicate all **incurred** uninsured treatment/medication expenses for generally accepted treatment and medication for the Hepatitis C infection. Please attach all receipts.

Date DD/MM/YYYY	Treatment/Medication Description	Receipt Enclosed	Total Cost	Amount Reimbursed by Health Plan	Amount Claimed
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$
/ /		Yes ☐	$	$	$

Out-of-Pocket Expenses – Log Sheet for Appointments Relating to Hepatitis C Infection

GEN 3

P-HCV$F-GN3/4

Name:		**Claim Number:**			**To Be Completed by Clinic/Hospital Staff**				
Date DD/MM/YYYY	**Name of Physician**	**Specialty**	**Km Traveled**	**Parking Fees**	**Clinic/Hospital Staff Signature or Stamp**	**HCV Related Visits**		**Follow-up visits for HCV Infection**	
						Time of Appointment	**Time of Departure**	**Yes**	**No**
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐
/ /				$				☐	☐

I certify that the information provided is true and correct. I am not making any false or exaggerated claims to obtain benefits that I am not entitled to receive.

Date Signed

HCV Infected Person's or Personal Representative' Signature