

INQUIRIES DIVISION

1250, René-Lévesque Blvd. W., Suite 3500, Montreal (Quebec) H3B 0G2

Tel.: 514-933-4441 or 1 888 633-3246

Fax : 514-933-2291 | deonto@cmq.org**COLLÈGE
DES MÉDECINS
DU QUÉBEC****Inquiries Division****Account conciliation request form**

To submit a request for conciliation of an account, fill out this form and send it to the Inquiries Division at the above address **with a copy of your invoice**.

Time limit:

- a) For an unpaid account, there is no time limit. However, the request must be submitted before proceedings are instituted in respect of an account.
- b) For a paid account, the time limit is 60 days following receipt of the account.

A – Your contact informationPronouns used: She He Others Prefers not to answer

Surname: _____ First name: _____

Address (no.): _____ Street: _____ Apartment (no.): _____

City: _____ Province: _____ Postal code: _____

Daytime telephone no.: _____ Email: _____

Preferred method of communication: Mail Secure email address**B – Physician's contact information**

Surname: _____ First name: _____

Name of the place where the service was provided: _____

Address where the service was provided:

Address (no.): _____ Street: _____ City: _____

C – Details of the request

Amount claimed by the physician: _____ Date(s) the fees were claimed: _____

Check the box that applies:

- Copy of the account attached to the form
- Copy of the document indicating the amount withdrawn or withheld attached to the form

I am disputing the account for the following reason(s):

Check the box that applies:

- I have not paid the account and I would like the amount to be revised to _____
- I have paid the account in full and would like a refund of _____
- I have paid the account up to the amount of _____
- The amount of _____ was withdrawn or withheld from funds that the physician holds or receives for me or on my behalf.

I am requesting conciliation under the [Regulation respecting the conciliation and arbitration procedure for the accounts of physicians](#) (c. M-9, r. 26).

Signature: _____ Date: _____