COLLÈGE
DES MÉDECINS
DU QUÉBEC

**Inquiries Division**
1250, boul. René-Lévesque W., Suite 3500
Montreal QC H3B 0G2
Email : info@cmq.org
Fax : 514 933-2291

# Application for conciliation of account

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

**Deadline:**

**a) In the case of an account not paid, there is no time limit, but the request must precede an action on the account**

**b) In the case of an account paid, the time limit is 60 days following receipt of the account**

Name of the client _____

Address of the client _____

_____

Daytime telephone _____

Email (for secure access) _____

Name of the physician _____

Name and address where the professional services were rendered _____

_____

Sum claimed by the physician _____

Date(s) of claim fees _____

**Check the appropriate box**

☐ Account of which a copy is attached hereto

☐ Document of which a copy is attached hereto, indicating that the sum was withdrawn or withheld

I contest this account for the following reason(s):

**Check the appropriate box**

☐ I have not paid this account and I want the amount to be revised to _____

☐ I have paid this account in full and I want a reimbursement of _____

☐ I have paid this account to a limit of _____

☐ The sum of _____ was withdrawn or withheld directly from the funds which the physician holds or receives for or on my name.

I apply for conciliation by the syndic pursuant to the *Regulation respecting the procedure for the conciliation and arbitration of accounts of physicians* (c. M-9, r. 26).

_____ _____

Signature Date