APPLICATION for OUT-of-PROVINCE
HEALTH BENEFITS

Manitoba Health

Attach to Out-of-Province Medical or Hospital Claim Form

Manitoba Health registration number: ⌊___|___|___|___|___|___|___⌋

Manitoba Health Personal Health Identification Number (PHIN): ⌊___|___|___|___|___|___|___|___|___|___⌋

Patient's Name: _____

Address: _____

_____

Phone Number: _____ _____
Home Work

Date(s) of treatment: _____
(day / month / year)

Where was treatment(s) provided?

❑ Doctor's office (Please complete Form #2)

❑ Hospital (Please complete Form #3)

❑ Private residence (house, apartment, hotel)

❑ Other (explain): _____

_____

Reason for absence from Manitoba:

❑ Vacation

❑ Employment

❑ Education (Letter of Acceptance/Confirmation of full-time attendance required)

❑ Other (explain): _____

Date of departure: _____

Date of return (expected): _____

The personal information you may be asked to provide is being collected under the authority of legislation and/or program policies under the jurisdiction of the Minister of Health. The information is required to provide health coverage and/or service and is protected under the protection and privacy provisions of The Freedom of Information and Protection of Privacy Act as well as The Personal Health Information Act. If you have any questions about the collection of personal information, please contact: Access and Privacy Coordinator, Manitoba Health, 1st Floor, 300 Carlton Street, phone 204-786-7101.

_____ _____

Signature Date

FORM #1
May 2004

OUT-of-PROVINCE CLAIM
MEDICAL (DOCTOR) SERVICES

Manitoba Health

Original bills (with a translation if necessary) must be submitted with all claims

Services provided at:

❑ Doctor's office ❑ Hospital ❑ Private residence (house, apartment, hotel)

Because of: ❑ Sudden illness ❑ Accident

❑ Give details: _____

_____

Doctor's name: _____

Address: _____

City: _____

Country: _____

Date(s) of service: _____

Diagnosis: _____

Surgery involved: ❑ No ❑ Yes

Type of surgery: _____

X-rays: ❑ No ❑ Yes

If yes, what area of the body: _____

Laboratory tests: ❑ No ❑ Yes

Type of tests: _____

Type of currency used to pay this account: Equivalent amount in CDN funds:

_____ _____

Has account been paid? ❑ No ❑ Yes (attach receipts)

Note: Failure to provide complete details may result in delay of payment.

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_____ _____

Signature Date

FORM #2

May 2004

OUT-of-PROVINCE CLAIM
HOSPITAL SERVICES

Manitoba Health

Original bills (with a translation if necessary) must be submitted with all claims

Name of hospital: _____

Address: _____

City: _____

Country: _____

Diagnosis: _____

Hospitalization required because of: ❑ Sudden illness ❑ Accident

Please give details: _____

_____

_____

Outpatient visit ❑ No ❑ Yes

Inpatient ❑ No ❑ Yes

Date of admission: _____
(day / month / year)

Date of discharge: _____
(day / month / year)

Type of currency used to pay this account: _____

Equivalent amount in CDN funds: _____

Has hospital been paid? ❑ No ❑ Yes (attach receipts)

Note: Failure to provide complete details may result in delay of payment.

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Signature _____ Date _____

FORM #3
May 2004