



Manitoba Health Appeal Board
 102 – 500 Portage Avenue, Winnipeg MB R3C 3X1
 T (204) 945-5408 **Toll Free** 1-866-744-3257 F (204) 948-2024
 Website www.manitoba.ca/health/appealboard

GENERAL NOTICE OF APPEAL

APPELLANT’S IDENTIFYING INFORMATION:

Name: _____ Date of Birth: _____
Surname Given Name

Address: _____
and Street Name City Postal Code

Telephone/Fax: _____ Email: _____
Home/Cell/Work/Fax

Preferred pronoun/s (optional): _____

Personal Health Information Number (PHIN): _____
 (9 digit number)

APPELLANT’S REPRESENTATION ON APPEAL:

I will be representing myself on this appeal.
 I will be represented by legal counsel:

Name Address Postal Code

I will be represented by another individual*: _____
Name and relationship to appellant

and Street Address City Postal Code Telephone # Email address

***Note:** Please see information set out at bottom of page 2 regarding an appellant’s representative.

ISSUE(S) UNDER APPEAL

TAKE NOTICE that pursuant to the provisions of *The Health Services Insurance Act* and its regulations, I hereby provide notice of my appeal to the Manitoba Health Appeal Board regarding the following decision made by:

Manitoba Health
 _____ Regional Health Authority
Name

Decision I am appealing: _____

(PLEASE PROVIDE A COPY OF THE WRITTEN DECISION FROM MANITOBA HEALTH OR WRITTEN DECISION FROM THE REGIONAL HEALTH AUTHORITY)

