



HEALTH BENEFITS

Insured Benefits Branch

300 Carlton Street

Winnipeg, MB R3B 3M9

Telephone: (204) 786-7303 Fax: (204) 772-2248

Email: outofprovinceclaims@gov.mb.ca

Hours: 8:30am - 4:30m (Mon-Fri)

Health, Seniors and Long-Term Care

Section 1: Personal Information

To be completed by the patient, or by the patient's parent, guardian, or authorized representative

Manitoba Health Registration Number: _____

Manitoba Health Personal Identification Number (PHIN): _____

Patient's name: _____

Date of birth: (dd/mm/yyyy) _____

Address: _____

Phone number: _____ Home/Cell _____ Work _____

Date(s) of treatment: (dd/mm/yyyy) _____

Temporary Out-of-Province (TOOP) Approved Dates (if applicable): Start _____ End _____

Absence from Manitoba:

Please give the reason for the absence: Vacation Work Education Sabbatical/Missionary
 Medical Other (specify) _____

Date of departure: _____ Date of return (expected): _____

Where was treatment(s) provided? Hospital Physician's office Medical Lab
 Other (explain): _____

Copies of invoices and receipts (with translation if necessary) must be submitted with all claims.

Take home prescriptions from out of country are not eligible for coverage and should not be submitted.

I declare that the information I have provided on this form is correct to the best of my knowledge.

Patient or Guardian's printed name: _____

Patient or Guardian's signature: _____

Date signed: (dd/mm/yyyy) _____



Health, Seniors and Long-Term Care

Application for OUT-of-PROVINCE CLAIM

HOSPITAL SERVICES

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Section 2: Hospital Care

Fill section if you were in a hospital or emergency department.

Did you go to a hospital? Yes

Hospital Information

Name of hospital: _____

Address: _____

City: _____ Country: _____

Amount billed in foreign funds: _____ Currency used: _____

Private Facility Information

Name of facility: _____

Address: _____

City: _____ Country: _____

Amount billed in foreign funds: _____ Currency used: _____

Reason for visit: _____

Outpatient visit: Yes No

Inpatient visit: Yes No

Hospitalization required because of: Sudden illness Accident Appointment

Other (specify) _____

Surgery involved: Yes No

If yes, type of surgery: _____

Date of admission: _____
(dd/mm/yyyy)

Date of discharge: _____
(dd/mm/yyyy)

Has account been paid? Yes No

Must attach copies of receipts

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Section 3: Physician

Fill section if you were seen by a physician outside of a hospital setting or claiming physician charges from a hospital/facility.

Services provided at: Physician's office Hospital Private Facility Private residence (house, apartment, hotel)

Because of: Sudden illness Accident Booked Appointment
 Other (specify) _____

Did you see a medical doctor? Yes No Type of Doctor: _____

Doctor's name: _____

Address: _____

City: _____ Country: _____

Amount billed in foreign funds: _____ Currency used: _____

Reason for visit: _____

Date(s) of service: _____

Section 4: Lab Tests

Laboratory tests (blood/urine): Yes No

If yes, what kind: _____

X-rays: Yes No If yes, what area of the body: _____

MRI, CT Scan, Ultrasound: Yes No

If yes, what area of the body: _____

Has account been paid? Yes No

Must attach copies of receipts.