APPLICATION for OUT-of-PROVINCE
HEALTH BENEFITS

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 204-786-7237.***

______ Signature

______ Date

FORM #1
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

OUT-of-PROVINCE CLAIM
MEDICAL (DOCTOR) SERVICES

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