Manitoba

Health, Seniors and Long-Term Care

Application for OUT-of-PROVINCE CLAIM

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)

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) _____

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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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PHYSICIANS SERVICES

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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.