

# APPLICATION for OUT-of-PROVINCE HEALTH BENEFITS

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

Insured Benefits Branch  
300 Carlton Street  
Winnipeg, MB R3B 3M9  
Telephone: (204) 786-7303  
Fax: (204) 772-2248



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 Out-of-Province Claim **MEDICAL (DOCTOR) SERVICES** form)

Hospital (Please complete Out-of-Province Claim **HOSPITAL SERVICES** form)

Private residence (house, apartment, hotel)

Other (explain): \_\_\_\_\_

\_\_\_\_\_

## Reason for absence from Manitoba:

Date of departure: \_\_\_\_\_

Date of return (expected): \_\_\_\_\_

Vacation

Employment

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

Other (explain): \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Should you have additional questions or concerns regarding out-of-province claims, you can visit Manitoba Health's Out-of-Province website at [www.gov.mb.ca/health/mhsip/leavingmanitoba.html](http://www.gov.mb.ca/health/mhsip/leavingmanitoba.html) or contact an out-of-province case coordinator at (204) 786-7303; toll-free (800) 392-1207 (ext. 7303); fax number (204) 772-2248.

*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.*

**OUT-of-PROVINCE CLAIM**  
**MEDICAL (DOCTOR) SERVICES**

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

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**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.**

**Signature**

**Date**

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**OUT-of-PROVINCE CLAIM**  
**HOSPITAL SERVICES**

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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 account been paid?  No  Yes (attach receipts)

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

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

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