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

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: ______________________

Address: ______________________

____

Phone Number: ______________________ Home ______________________ Work

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

Temporary Out-of-Province (TOOP) Approved Dates: Start __________ End __________

Absence from Manitoba:

Please give the reason for the absence: ☐ Vacation ☐ Work ☐ Education ☐ Sabbatical ☐ Missionary ☐ Other

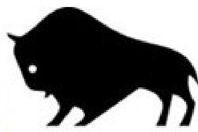
Date of departure: ______________________

Date of return (expected): ______________________

Where was treatment(s) provided?

☐ Physician's office
☐ Hospital
☐ Medical Lab
☐ Other (explain): ______________________

____



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HOSPITAL SERVICES

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

Section 2: Hospital Care

Did you go to a hospital? ☐ Yes ☐ No

Hospital Information

Name of hospital: ____________________

Address: ____________________

City: ____________________

Country: ____________________ Currency Used: ____________________

Private Facility Information

Name of Facility: ____________________

Address: ____________________

City: ____________________

Country: ____________________ Currency Used: ____________________

Diagnosis: ____________________

Hospitalization required because of: ☐ Sudden illness ☐ Accident ☐ Appointment

Other (specify) ____________________

____

Outpatient Visit ☐ Yes ☐ No

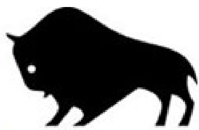
Inpatient ☐ Yes ☐ No

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

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

Has account been paid? ☐ Yes ☐ No

Must attach copies of receipts.

Manitoba 

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PHYSICIANS SERVICES

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

Section 3: Physician Services

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? If so ☐ Yes ☐ No

Doctor's name: ______________________

Type of Doctor: ______________________

Address: ______________________

City: ______________________

Country: ______________________ Currency Used: ______________________

Date(s) of service: ______________________

Section 4: Lab Tests

Surgery involved: ☐ Yes ☐ No

Type of surgery: ______________________

X-rays: ☐ Yes ☐ No

If yes, what area of the body: ______________________

Laboratory tests: ☐ Yes ☐ No

Type of tests (X-Ray, MRI, CT Scan, Ultrasound etc.) ______________________

Copies of bills (with translation if necessary) must be submitted with all claims.

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: ______________________

Date:
(dd/mm/yyyy) ______________________

Patient or Guardian's Signature: ______________________

Has account been paid? ☐ Yes ☐ No

Must attach copies of receipts.