

**BEFORE YOU BEGIN…**

**Your Medical and Personal Expenses**

**You can claim:**

* Prescriptions and over-the-counter medicines needed for your injuries
* Bandages, dressing or other medical supplies needed for your injuries
* Prescription glasses damaged in the accident
* Dental work needed from your injuries

**Tips for making your claim and filling out the form:**

* To claim prescription drugs, attach legible copies of your original Pharmacare receipts.
* To claim any other expenses, attach legible copies of your original receipts.
* To claim damaged glasses, list the cost to repair or replace them. *Keep your damaged glasses – your case manager will need to see them*.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MPI S by S 3155 Logo | | | | | **Claim No.: 1034721756** | | | | |
| **Case Manager:** Karen Henderson | | | | |
|  | | | | | **Claimant’s Name: Eduard Hiebert** | | | | |
|  | | | | |  | | | | |
| **Your Medical Expenses** | | | | | | | | | |
| **Checklist** | | | | | | | | | |
| * For prescriptions, attach legible copies of your original Pharmacare receipts * For all other expenses, attach legible copies of your original receipts * Claim only expenses related to your injury | | | | | | | | | |
|  |  | | | | | | | | |
| **STEP 1** | **List your prescriptions and over-the-counter medicines** | | | | | | | | |
| Office use only | | Date of Purchase | Medicine | Why you needed this medicine | | | Your physician’s name | | How much |
| ***EXAMPLE*** | | *10-June-07* | *Tylenol #3* | *Relieve low back pain* | | | *Dr. Smith* | | *$13.65* |
| **1** | |  |  |  | | |  | |  |
| **2** | |  |  |  | | |  | |  |
| **3** | |  |  |  | | |  | |  |
| **4** | |  |  |  | | |  | |  |
| **5** | |  |  |  | | |  | |  |
| **6** | |  |  |  | | |  | |  |
| **7** | |  |  |  | | |  | |  |
| **8** | |  |  |  | | |  | |  |
| **9** | |  |  |  | | |  | |  |
| **10** | |  |  |  | | |  | |  |
|  | |  |  |  | | | **Subtotal medicines** | | $ |
| **STEP 2** | **List your other personal expenses such as eyeglasses, braces and so on** | | | | | | | | |
| Office use only | | Item | Date of Purchase | Seller’s name | | | Name of person who paid | | How much |
| ***EXAMPLE*** | | *Eyeglasses* | *10-June-07* | *Anyplace Optical* | | | *Mr. Ted Jones* | | *$150.00* |
| **1** | |  |  |  | | |  | |  |
| **2** | |  |  |  | | |  | |  |
| **3** | |  |  |  | | |  | |  |
| **4** | |  |  |  | | |  | |  |
| **5** | |  |  |  | | |  | |  |
| **6** | |  |  |  | | |  | |  |
|  | |  |  |  | | **Subtotal other person expenses** | | | $ |
|  | | | | | | | | | |
| **STEP 3** | **Add your subtotals together** | | | | | | | **Total claimed** | $ |
|  | | | | | | | | | |
| **STEP 4** | **Sign and date this form, below. Without your signature and a date, we can’t pay you.** | | | | | | | | |
| *All the information I’ve provided on this form is true.* | | | | | | | | | |
| Signature | | | | | | | Date | | |
| Current Address | | | | | | | | | |
| |  |  | | --- | --- | | **STEP 5** | **Please return the completed form to:** |   Manitoba Public Insurance  Injury Claims Management  P.O. Box 6300  Winnipeg, MB R3C 4A4  Fax Number: 204-954-5332 | | | | | | | | | |