

**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*.

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| 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
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|  |  |
| **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 |
|

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| **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 |