

FOR MANITOBA HEALTH USE ONLY

Prosthetic and Orthotic Claim Form

Provincial Policy and Programs
300 Carlton Street
Winnipeg, Manitoba
R3B 3M9

Manitoba 
Health, Healthy Living & Seniors

SUPPLIER

NAME	ADDRESS	SUPPLIER NO. 0
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PATIENT

SURNAME		GIVEN NAME		DATE OF BIRTH Day Mo. Yr.		SEX M F	SCOL.
M.H. REG. NO.	P.H.I. NO.	FAMILY HEAD (Required if patient is dependant)				DELIVERY DATE Day Mo. Yr.	
<input type="checkbox"/> IN - PATIENT <input type="checkbox"/> OUT - PATIENT	HOSPITAL NAME		CERTIFIED ORTHOTIST/PROSTHETIST NO.				

PRESCRIBING PHYSICIAN

M.H. USE

DEVICE AND / OR REPAIR DATA

DESCRIPTION	INVOICE NO.	IDENTIFIER / DESCRIPTOR	QTY.	DOLLARS PER DEVICE
1.				
2.				
3.				
4.				
5.				

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Name of Miscellaneous or Out-of-Province Supplier

Total Cost
\$

Address

Total Manitoba
Health Payment
\$

Postal Code

REJECT
CODEBY-PASS
CODE