



Please complete this form when requesting reimbursement and/or pre-approval of service expenses.

REQUEST FOR REIMBURSEMENT

All services are subject to availability of monetary resources.

Name

Address

City, Province

Postal Code

Phone

PLEASE DESCRIBE THE COVERAGE YOU ARE REQUESTING *Original receipts must be attached for reimbursement*	Cost
Total	

Are these services available to you from any of the programs listed below? Yes No

- | | |
|----|--|
| \$ | Blue Cross |
| \$ | Manitoba Health |
| \$ | Life Saving Drug Program |
| \$ | Society for Manitobans with Disabilities |
| \$ | A private insurance plan or employment benefit |
| \$ | Other – Details: |

Would you like help finding other assistance programs that might be available? Yes No

Please see policy for items that REQUIRE authorization from a member of the Manitoba Bleeding Disorders Program (MBDP) treatment team. If this policy applies to this request, please have the appropriate team member complete this section.

I, _____ (Please print team member's name and profession/occupation),
verify that I have recommended the above treatment/service.

Signature of MBDP Team Member: _____ Date: _____

I am fully aware that Bleeding Disorders Manitoba only covers expenses that are listed
in its Member Services Policy and that all decisions of the Board of Directors are final
and binding. You can find Member Services at www.hemophiliamb.ca/member-services.

Applicant's Signature: _____ Date: _____

PLEASE ALLOW 4 TO 6 WEEKS FOR PROCESSING

Suite 140, 162-2025 Corydon Ave Winnipeg, MB R3P0N5

Office use only:

Approved by: _____

Amount: \$ _____

Cheque # _____

Date: _____