Canadian Hemophilia Society
Manitoba Chapter

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 CHS-MC 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 Serivces at www.hemophiliamb.ca/member-services.

Applicant's Signature: _______________________________ Date: ___________________

PLEASE ALLOW 4 TO 6 WEEKS FOR PROCESSING

CHS-MC use only:

Approved by: ____

Amount: $ __________________________

Cheque # __________________________

Date: __________________________