

SCHEDULE "A"
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby consent to and authorize Manitoba Health to furnish to any representative of _____, claim and payment information in Manitoba Health's possession in respect of claims for Medical Services incurred for which I had insurance coverage from _____ including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory services).

ASSIGNMENT OF PAYMENT DUE TO REGISTRANT UNDER THE HEALTH SERVICES INSURANCE ACT

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby direct Manitoba Health to forward payment to _____, for any claims for benefits under the Health Services Insurance Act submitted by _____ in respect for medical and hospital services provided outside Canada.

DATED this _____ day of _____, 20____

Manitoba Health Registration Number SIGNATURE

Address

Personal Health Identification Number Telephone

 For Claim inquiries, call **1-800-336-9224** or **819-566-8698**.