

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

Tips for making your claim and filling out the form:

- To claim prescription drugs, attach legible copies of your original Pharmacare receipts.



**FRIENDLY DRUG MART**  
420 Fairbridge Dr. Anytown AB T3J 3K8  
Store # 35 Phone (403) 293-2605

**OFFICIAL PRESCRIPTION RECEIPT**

Rx# 704524 Refills: 000 Patient Pays: **\$7.40**  
Optimum: 90081326

**SMITH**  
10212-56 ST.  
ANYTOWN AB 1A5 T3J

**PATRICIA (TRISH)**  
Phone: (403) 321-4567

**Dr. J. DOE**  
Date: 19-Jan-01  
NOLOLIN ge NEN PENFI PH  
3ML  
15 ML

**DIN 02268024** Tx# 62968

Mfg: CON  
**TOTAL: \$36.99**  
PC: BE

**Official Prescription Receipt**

**Drug claims must show the DIN number**

Pharmacist's Signature:

- 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.*
- All expenses will be reviewed prior to payment being processed.



Customer: \_\_\_\_\_  
Claim Number: \_\_\_\_\_  
Date of Loss: \_\_\_\_\_

## Your Medical Expenses

Office use only	Date of Purchase	Medication	Your physician's name	Cost of Medication
<b>EXAMPLE</b>	<i>January 19, 2020</i>	Nololin PH	<i>Dr. J. Doe</i>	<i>\$36.99</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Office use only	Date of Purchase	Other personal expenses	Seller's name	Cost of item purchased
<b>EXAMPLE</b>	<i>June 7, 2020</i>	<i>Eyeglasses</i>	<i>Anyplace Optical</i>	<i>\$150.00</i>
1				
2				
3				
4				
5				
6				

Sign and date this form, below. Ensure all Pharmacare receipts for prescriptions and cash register receipts are attached for all non-prescription expenses. Without your signature, date and receipts, we cannot reimburse you.

\_\_\_\_\_  
Signature of Customer

\_\_\_\_\_  
Date (dd/mm/yy)

\_\_\_\_\_  
Customer Address

**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