Assignment of Benefits to Provider

Service Recipient _____ **Date of Birth** _____

Plan Member Information

Plan Number_____ Identification Number_____

Name _____ Date of Birth_____

Address_____ City/Town_____

Province_____ Postal Code_____

Telephone Number_____

Provider Information

Medigas Manitoba Limited
150 McPhillips Street
Winnipeg, MB R3E2J9
Telephone Number 204.786.4719

Provider Signature (or stamp) _____ Date _____

Authorization

I, _____ hereby assign my benefits payable from this claim directly to Medigas Manitoba Limited for medical equipment and supplies provided. **I understand that I am financially responsible to the provider for the entire cost associated with this claim.**

I authorize Medigas, its employees and authorized agents to share my personal information with my insurance provider.

Plan Member Signature _____ Date _____

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