Children's Opti-Care Program Claim Form

Manitoba

Manitoba Families
Provincial Services
100 – 114 Garry Street
Winnipeg, MB R3C 4V4
Phone: 204-948-7368
Toll Free: 1-877-587-6224
E-mail: incsup@gov.mb.ca

Instructions:

- Answer all questions in Part 1 on this form.
- Have your eye doctor or optician fill in and sign Part 2 of this form.
- Mail or fax the completed claim form **and your child's eyeglass receipt(s)** to the address above.

Note:

- Your family must be getting the Manitoba Child Benefit to apply for this program.
- If you get eyewear benefits from any other health insurance plan, you cannot apply to this program.
- You must send your claim within **14 months of the date you bought the glasses**.
- You cannot make a claim for glasses you bought before January 1, 2012.

Part 1 – Patient Information

Parent/Guardian's Last Name	First Name	Social Insurance Number
Address (Number and Street Name)	City/Town / Province	Postal Code
Child's Last Name	First Name	Birth Date (Day / Month / Year)

Privacy Protection:
I understand that the personal information about me and my children is protected by ***The Freedom of Information and Protection of Privacy Act*** and ***The Personal Health Information Act***. This information will only be used to assess my eligibility for the Children's Opti-Care Program. It will not be used for any other purpose, without my permission.

I confirm that the above information is accurate.

Signature of applicant/parent/guardian _____ Date _____

Part 2 – Eye Care Provider / Child Prescription Information

Prescription Details:

	R	L
Sphere:		
Cylinder:		
Axis:		
Prism 1:		
Base 1:		
Prism 2:		
Base 2:		
Add:		

Reason for Purchase: *(please check)*

a) Initial prescription ☐
b) Prescription change ☐
c) Other *(please specify)* ☐

Cost:

Lenses $ _____
Frames $ _____
Other (*please specify*) $ _____
Total Cost: $ _____

I am a legally qualified Manitoba ☐ Ophthalmologist ☐ Optometrist ☐ Optician

Provider's Signature _____

Provider's Phone No. _____ Date of Purchase _____

I certify that the treatment above was provided and all the information on this form is accurate.