MANITOBA ADULT INSULIN PUMP COVERAGE PROGRAM APPLICATION FORM

Manitoba Health

FAX: (204) 944-2415

Manitoba Health
300 Carlton Street
Winnipeg MB R3B 3M9

Prescriber Name:	**Fax Number:** **Phone Number:**
Prescriber Address:	**Prescriber License Number (NOT Billing Number):**

Patient's First Name:	**PHIN:**	**MH Registration Number:**
Patient's Last Name:	**Patient's Date of Birth:**	

Confirmation of Patient Eligibility:	**Yes**	**No**
This application is being made by (a) an endocrinologist or (b) a medical practitioner, who is providing care to the eligible insured person in relation to the management of their diabetes.	◯	◯
The medical practitioner making this application is satisfied that the eligible insured person **(a) is currently safely using an insulin pump; OR** **(b) is capable of safely using an insulin pump and the use of the pump will assist the person in their ongoing efforts to manage their blood glucose level.**	◯	◯
The client is at least 18 years of age.	◯	◯
The client has been diagnosed with type 1 diabetes.	◯	◯
The client has not received an insulin pump within the last five years under the Prosthetic, Orthotic and other Medical Devices Insurance Regulation or under the Manitoba Pediatric Insulin Pump Program.	◯	◯

This application is for an insulin pump device from an approved supplier.*

*A list of approved suppliers and devices is available here.

Prescriber Signature			
Date:		**Prescriber Signature:**	