Manitoba
Health and Healthy Living
Health Workforce/Insured Benefits Branch
3rd floor 300 Carlton Street
Winnipeg MB R3B 3M9

Letter of Agreement

I, _____, acknowledge that I am responsible for ensuring the accuracy and validity of all described and coded services submitted under Practitioner Billing No. _____ to the Insured Benefits Branch, Manitoba Health via electronic communication.

I further acknowledge that all information submitted in connection with my claims is subject to the provisions of *The Health Services Insurance Act*.

I agree to notify Manitoba Health immediately upon termination of my practice at the location denoted by the user number listed below.

Start date _____

User Number _____

_____ _____
Practitioner Signature Date

_____ _____
Witness Signature Witness Name