

WSIB CLAIM HISTORY

Please complete the following to help us process your WSIB claim as quickly as possible, Thank you!

Name _____		Social Insurance No. _____	
Birthdate (dd/mm/yyyy) _____		Claim # (if known) _____	
Address _____		City _____	Prov. _____ PC _____
Home Phone # _____		Work Phone # _____	
Employer Name _____			
Address _____		City _____	Prov. _____ PC _____
Phone # _____	Fax # _____	Contact Person (HR) _____	

What was the date of your accident/injury? (DD/MM/YYYY) _____

Describe what happened to cause your accident/injury: _____

Describe the nature of your injury/symptoms: _____

Were you referred by another health practitioner? Yes No Name: _____

Have you already been treated for this condition? Yes No Explain: _____

Have you had a similar medical condition in the past? Yes No Explain: _____

Have you ever filed a claim with WSIB in the past? Yes No Reason: _____

Are you currently off work as a result of your injury? Yes No

Are you currently on restricted (light) duty due to your accident? Yes No

FINANCIAL POLICY FOR WSIB CLAIMS

If you have been injured at work and are filing a WSIB claim, please **notify the staff**, your **doctor**, and **your employer immediately**. Your employer (Human Resources Dept.) must complete an injury report and may have forms for you to complete in order for WSIB to consider your claim. Your doctor will complete a **Chiropractor's First Report (Form C640)** outlining your injuries and treatment plan, and may require a **Functional Abilities Form (C901)** from your employer if you are required to be off work or placed on light (restricted) duty for any length of time. WSIB will not consider your claim unless all documents relating to your case are submitted. Once all forms have been received by WSIB, your claim will be considered and approval for treatment should be received within 2-4 weeks. Once approved all claims for services are billed directly to WSIB and are not the responsibility of the patient.

Due to delays in processing claims, however, you **may** be required to pay for services that you receive before your claim has been submitted or approved. **If you do not pay for these services, and for any reason your claim is denied, you (the patient) will be responsible for paying the entire balance owing for services that have been rendered.**

I, _____ have read and fully understand the above financial policy related to WSIB claims and would like Norfolk Chiropractic Wellness Centre to hold a balance for me pending insurance approval for my claim. (Patient Signature) _____.