Form HA-02
Exception Report
Doc Code (MP) Internal Use Only

Please MAIL this form to:
P.O. Box 160
Saint John, N.B.
E2L 3X9

Please fax this form TOLL-FREE to: **1 888 629-4722**

Toll-free telephone number: **1 800 222-9775**

Service Provider Name and Address	**Worker Name and Address**
Service Provide Payee Number	**Claim Number**

Date of Worker Appointment/Visit **YYYY-MM-DD**	**Product or Service Required**

Hearing Aid Original Purchase Date **YYYY-MM-DD**	**Hearing Aid Serial #**

Why Product(s) or Service(s) is Required

List Attachments *(Please attach any related documentation such as hearing re-evaluation or full diagnostic hearing assessment reports)* **Total # of Attachments** _____ **Total # of Pages Attached** _____	**Additional Notes or Comments**

The undersigned declares the above requested service(s) is not the result of abuse or negligence of the worker.

YYYY-MM-DD	Print Name	Signature

Note: If worker is claiming mileage for this visit, WorkSafeNB will also use this form as confirmation of visit for mileage reimbursement.