



## Medical Aid Request

**IMPORTANT:** Save this form to your computer or network drive and complete the form from that version. Do not complete this form from an online browser.

Use this form if you had an approved claim that is now closed (no longer receiving any benefits from WorkSafeNB such as loss of earnings or medical aid) and require medical aid for your previously approved work-related (compensable) injury or illness. A medical aid is any product or service that helps you recover or manage your workplace injury or illness. Examples include chiropractic service, physiotherapy, transportation aids (such as wheelchair ramp or replacement part), dental aid or service, TENS machine or TENS machine supplies, footwear, orthotics, braces, crutches, gloves and glasses. **This form is not for travel reimbursement or hearing aid-related requests.** For these requests, see [Travel Expense Form](#) and [Hearing Aids](#).

### 1. Your information

Last name		First name		Previous claim number	
Street address				Apt. no.	
Town/City		Postal code	Province	Phone number (cell)	
Phone number (home/other)	Preferred time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon		Email address		Date of birth
Social insurance number		Medicare number		Family doctor/nurse practitioner	
Injury/Illness start date	Body part(s) injured			Specify left, right or both if applicable <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	

### 2. Medical aid

Have you received this type of medical aid before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, on what date?	Is this a replacement item? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you receive a referral/recommendation for this medical aid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include this with request.	
Do you have a cost estimate (quote) for this aid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include this with request.	
Is there a web link for this aid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide link:	
If a service, such as chiropractic treatment and physiotherapy, has this treatment started? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, treatment provider name:	Start date:
Please select the medical aid you need:	
<input type="checkbox"/> Braces, crutches or other mobility support (please specify)	
<input type="checkbox"/> Footwear, orthotics	
<input type="checkbox"/> TENS machine or TENS machine supplies	
<input type="checkbox"/> Glasses	
<input type="checkbox"/> Physiotherapy	
<input type="checkbox"/> Surgical aid (please explain procedure)	
<input type="checkbox"/> Chiropractic service	
<input type="checkbox"/> Prosthetics or prosthetic device (please specify)	



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- ☐ Transportation aid (ramp, wheelchair part, etc.) (please specify)
- ☐ Hospital or nursing services (please specify)
- ☐ Dental aid or service (please specify)
- ☐ Glove(s) (please specify glove type)

Do you use the glove(s) for work? ☐ Yes ☐ No

Other (please specify)

Please use this space for any additional information (1,800 character limit):

### 3. Declaration and consent

- ☐ I declare that that all the information provided by me is true and correct to the best of my knowledge.
- ☐ I consent and authorize WorkSafeNB to gather, use, release or disclose information from this claim, including medical and financial information, as authorized by law or otherwise as may be reasonable in WorkSafeNB's management or assessment of my claim(s), including disclosure to third parties. WorkSafeNB takes the protection of your privacy seriously.

Name	Signature	Date
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### 4. Confirmation and submission

Before submitting, have you:

- ☐ Completed all sections in full?
- ☐ Uploaded or included referral/recommendation (if available)?
- ☐ Uploaded or included a quote/cost estimate (if available)?

Here are your options for submitting this request:

#### MyServices

MyServices is the most secure and convenient way to submit documents to WorkSafeNB. To register, you'll need your social insurance number or Medicare number and the date of birth WorkSafeNB has on file. [Register here.](#)



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### Email

Email to [app-dem@ws-ts.nb.ca](mailto:app-dem@ws-ts.nb.ca). Please state "Medical Aid Request" in the subject line. WorkSafeNB reminds you that submitting documents through unsecure email networks increases privacy concerns. For more information, please read WorkSafeNB's [Access to Privacy and Information](#) statement.

### Mail

WorkSafeNB, 1 Portland Street  
PO Box 160, Saint John, NB E2L 3X9

### Fax

Toll-free 1 888 629-4722

To learn more about the claims process, potential benefits available, and healthy and safe return to work, please go to [worksafenb.ca/workers](http://worksafenb.ca/workers). If you have any questions, please contact us toll-free at 1 800 999-9775 (Monday to Friday, 8 a.m. to 4:30 p.m.)