Application for Medical Aid

IMPORTANT: Save this form to your computer or network drive before filling it out.
Do not complete this form directly from a web browser.

This form is not for travel reimbursement, prescription medication, hearing aid-related requests or compensation for a previously accepted claim. For these requests, see Travel Expense Form, Direct-Pay Prescription Drug Program, Hearing Loss Information and Resources and Application for Compensation Benefits.

1. Your information

Last name		First name		Previous claim number
Street address				Apt. no.
Town/City	Province	Postal code	Phone number (cell)	Phone number (home/other)
Medicare number		Email address		Date of birth (YYYY-MM-DD)
Social insurance number		Family doctor/nurse practitioner		Date of accident/injury/illness (YYYY-MM-DD)
Body part(s) injured		Specify left, right or both if applicable ☐ Left ☐ Right ☐ Both		

2. Medical aid

Have you received this type of medical aid before? ☐ Yes ☐ No If yes, on what date?
Is this a replacement item? ☐ Yes ☐ No

Did you receive a referral/recommendation for this medical aid? ☐ Yes ☐ No If yes, submit with this request (see section 4)
Do you have a cost estimate (quote) for this medical aid? ☐ Yes ☐ No If yes, submit with this request (see section 4)

If requesting a service, such as chiropractic treatment or physiotherapy, has this treatment started? ☐ Yes ☐ No

If yes, treatment provider or clinic name: Start date:

Please select the medical aid you are requesting:

☐ Treatment (physiotherapy, chiropractic, etc.) (please specify):
☐ Surgery (specify procedure):
☐ TENS machine or TENS machine supplies
☐ Footwear or orthotics
☐ Gloves (please specify glove type): Do you use gloves at work? Yes ☐ No ☐
☐ Prescription eyeglasses (attach prescription)
☐ Dental aid or service (please explain):
☐ Braces, crutches or other accessibility/mobility equipment (ramp, wheelchair part, etc.) (please specify):
☐ Prosthetics or prosthetic device, including any repair or replacement (please specify):
☐ Home care services (receipt required) (please specify):
☐ Other (please explain)

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

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3. Banking information

If your banking information has changed since your last payment from us, and you are looking for reimbursement for medical aid, please complete the banking information section below:

Branch number: (may also be called "transit" number)

Financial institution:

Account number: (usually 7 digits / may be more depending on bank)

You'll find the banking numbers needed on the bottom of your cheques. Alternatively, you may find the numbers by visiting your financial institution's website and viewing the "Direct Deposit" or "Pre-authorized Payment" tabs. (Naming conventions may vary.) Note: You do not need to provide banking information if you are submitting this form for information purposes only (not seeking medical treatment and/or wage replacement.)

4. Confirmation

Before submitting ensure you have:

- ☐ Completed all sections in full
- ☐ Uploaded or included receipt (if applicable)
- ☐ Uploaded or included referral/recommendation (if available)
- ☐ Uploaded or included a quote/cost estimate (if available)
- ☐ Included your claim number on all documents

5. 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 the WorkSafeNB management or assessment of my claim(s), including disclosure to third parties. WorkSafeNB takes the protection of your privacy seriously.

Name	Signature (worker or representative)	Date

6. Submission

Here are your options for submitting this request:

MyServices
MyServices is the most secure and convenient way to upload and 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

Email
Email to app-dem@ws-ts.nb.ca. WorkSafeNB reminds you that submitting documents through unsecure email networks increases privacy risk of data insecurity. 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 how to have a healthy and safe return to work, please go to 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.)