WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Halifax Office
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Sydney Office
336 King's Road, Suite 117
Medical Arts Building
Sydney, NS B1S 1A9
1-800-880-0003 toll free
902-563-2444 local
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Chiropractic Care Approval/Extension

05/2004

WCB use only.

Location:

Section A Worker Information

Worker's name: _____ Claim #: _____

Injury: _____ Accident date: _____

SIN: _____ Health card #: _____

Section B Treatment Requested

☐ Chiropractic ☐ Work conditioning/hardening ☐ Other: _____

Date of initial visit (dd/mm/yyyy): _____ Treatments to date: _____

Area(s) treated: _____

Total treatments requested: _____ Frequency: _____ times per week for _____ weeks

☐ Approval to (dd/mm/yyyy): _____ Initial report (Chiropractic Report) attached? ☐ Yes ☐ No*

☐ Extension to (dd/mm/yyyy): _____ Progress report (Chiropractic Report) attached? ☐ Yes ☐ No*

☐ Other (including TENS, braces, etc.): _____

***Approval cannot be given until the appropriate reports are received.**

_____ _____ _____

Chiropractor's signature Telephone and fax Date

Section C Approval/Denial

☐ Approval for referral to _____ (list recommended concurrent program).

☐ Total treatments approved:_____ Frequency of treatments: _____ times per week for_____ weeks.

☐ Claim number has not yet been assigned. Request will be reviewed again when claim number assigned.

☐ Cannot approve treatment until Chiropractic Report is received. Request will be reviewed again upon receipt of this report.

☐ Further documentation required from: ☐ Family Physician ☐ Employer ☐ Worker

☐ Claim is under review, and therefore, not yet approved. Response will be provided by _____ or when claim is approved.

☐ Claim is disallowed. No payment made by WCB.

☐ Treatment is disallowed. To discuss this decision, please contact the WCB.

☐ Other: _____

_____ _____ _____

Caseworker's name (Please print.) Telephone and fax Date

WCB use only.
Chiropractor's name_____ Contact code_____
Clinic name_____
Street_____ Telephone_____
Province/Postal Code_____ Fax_____