You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Send this form to appropriate insurer:

Fax # _____

Important Information about Your Personal Information

Confirmation of Services Provided
(Form AB-2a)

Use this form for accidents that occur on or after October 1, 2004.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner

Insurance Company	
Policy Number:	
Date of Accident: (DD-MM-YYYY)	

Part 1 Claimant Information

Last Name	First Name	Date Of Birth (DDMMYYYY)
Date of Initial Assessment (DD-MM-YYYY)		

Part 2 Primary Health Care Practitioner Information

Last Name	First Name	Date of Initial Assessment (DD-MM-YYYY)
Administrative Contact Name		Telephone Number (Include area code)

Part 3 Adjunct Therapy Provider Information

(To be completed by Acupuncturist or Massage Therapist for reimbursement of Services)

Name of Adjunct Therapy Provider		
Address		
City, town or county	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

Please list all services that have been provided to date. Note: The expenses of these services are secondary to those covered by Alberta Health Care Insurance. Amounts listed on the table or in the attachment should be net of any reimbursement by Alberta Health Care Insurance.

Part 4 Treatments and Services

☐ Additional sheets attached with claimant's signature if information is not listed on this page

Item	Date	Description of Service and Name of Service Provider	$ Amount

Part 5 Claimant Confirmation

☐ I am the claimant or ☐ I am the authorized representative of the claimant

I confirm that I have received the treatment, supplies or services identified on this form or the signed attachments. I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of Form AB-1 and regarding my eligibility for accident benefits as outlined on Form AB-1.

Name (Please Print) _____

Signature _____
Date_____

Part 6 Confirmation of Adjunct Therapy Provider

I confirm that I have provided the treatment, supplies or services identified on this form or have signed the attachments.

Signature _____
Date_____

Part 7 Confirmation of Primary Health Care Practitioner

I confirm that I have provided the treatment, supplies or services identified on this form, or have authorized the adjunct therapy provider for these services or have signed the attachments.

Signature _____
Date_____

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