WSNB infomation

Patient Name _____ Claim number _____

Name of Case Manager _____ Phone number_____

Please be advised that your WSNB coverage is dependent upon certain criteria:

- In order to initiate the claim process, both your doctor and employer must submit forms to WSNB.
- Throughout your treatment, WSNB requires letters from both your therapist and your doctor. **It is your responsibility** to contact your case worker to determine how often you are required to see your doctor and have them forward progress letters to WSNB.
- You should be aware at all times of the status of your WSNB claim (approval granted/denied). In the event that WSNB determines that your claim has been denied or you are no longer eligible for coverage, **it will be your responsibility** to cover payment for the services provided.

RELEASE OF INFORMATION

The Worker's Compensation Board of New Brunswick requires that we contact your case manager in relation to your functional abilities following your work related injury so that we may assist in planning your return to work.

I, _____ will provide pt Health with the information regarding my private medical insurance and permission to bill them, should my WSNB claim be denied.

_____
Signature

_____
Date

_____
Witness

Motor Vehicle Collision Client Information

Patient Name: _____ Date of Accident _____

MVC Insurance Co. _____ Adjuster_____

Phone _____ Fax _____

Policy Number _____ Claim Number _____

Billing options

- **Billing within Protocol**. Please fill in the required forms.

- **Not using Section B benefits**. I _____ have had the Section B billing explained to me and I have chosen with full knowledge to have treatment at pt Health without using the Section B benefits.

Signature:_____ Date: _____

Witness: _____

For Office Use Only

Contact Date: _____ **Bill Direct:** ☐ **Yes** ☐ **No**

Additional Notes: _____

_____

_____

_____

MVC Contact Inits: _____ Date: _____

pt Health
SOLUTIONS TO GET WELL & STAY WELL

Third Party Insurance Details for Direct Billing

Primary Plan

Service	PHYSIO	MASSAGE	CHIRO	Occupational Therapy
Referral Required	Y N	Y N	Y N	Y N
Max Per Year				
Covered at %				

Seconday Plan (if applicable)

Service	PHYSIO	MASSAGE	CHIRO	Occupational Therapy
Referral Required	Y N	Y N	Y N	Y N
Max Per Year				
Covered at %				

Billing Options (please check):

◯ 1. I agree to have the clinic direct bill my insurance plan. All information and forms have been given and signed. I fully understand the policy for direct billing.

◯ 2. I prefer to pay upfront and submit my treatment receipts on my own.

_____

Signature

_____

Date

_____

Witness