WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Claims and General Information
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Service Provider – Assistive Devices Request Form

WCB Claim Number	Health Card Number

A. REQUEST INFORMATION (to be completed by Case Worker)

To:	Fax:	Phone:
From:	Fax:	Phone:
Re:		

B. WORKER INFORMATION (to be completed by Case Worker)

Worker's Name	Compensable Injury	Body Part(s) Injured

C. DEVICE INFORMATION (to be completed by health care provider; attach additional page if necessary; also complete Section D if prescribing orthotics/footwear)

Type of Device	☐ New ☐ Replacement	Cost $	Warranty (Please attach any product/warranty info) ☐ Yes ☐ No Date of Expiry: _____

Please provide rationale and benefit of device in relation to compensable injury. Where necessary, provide medical and/or scientific evidence to support the request.

_____

_____

_____

_____

_____

D. ORTHOTICS AND FOOTWEAR (to be completed by service provider; please print)

☐ Orthotics	If prescribing/providing orthotics, can they be worn in standard footwear? ☐ Yes ☐ No
☐ Footwear	If providing custom footwear, please provide rationale as to why off the shelf footwear is not suitable. _____ _____
Leg Length Discrepancy ☐ Yes ☐ No	If yes, indicate the discrepancy:

If prescribing/providing replacement orthotics/footwear, please confirm that current orthotics/footwear have deteriorated to a state that they are no longer providing a mechanical or medical benefit. ☐ Yes ☐ No

E. SERVICE PROVIDER INFORMATION (to be completed by service provider; please print)

Name and Professional Designation:		WCBID#:
Signature:	Phone:	Fax:

F. WCB RESPONSE (to be completed by WCB Case Worker)

Is Device Approved? ☐ Yes ☐ No		Screen 119 updated Yes ☐ Initials:
WCB Case Worker (print):	Phone:	Date (dd/mm/yyyy):