



WorkSafeBC Claims Information

Client Name (please print): _____

Date of Injury: ____/____/____
(Year / Month / Day)

WorkSafeBC Claim #: _____

WorkSafeBC Case Manager: _____

Case Manager's Phone: (____) _____

Employer's Name: _____

Employer's Phone: (____) _____

Job Title: _____

Job Description/Duties: _____

Have you submitted all paperwork to WorkSafeBC? Yes No

GP Referrers Name: _____

I _____ hereby allow Parkway Physiotherapy + Performance Centre to charge my Credit Card # in the event that WCB refuses physiotherapy funding. Parkway Physiotherapy + Performance Centre will notify you of these charges if applicable.

NAME ON CARD _____
CREDIT CARD # VISA/MC _____ **EXPIRY DATE** _____
SIGNATURE _____

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This section for office use only:

- PHN entered in CM
- Start: ____/____/____
(Initial Day / Month / Year)
- End Date: ____/____/____
(Day / Month / Year)
- Stream 1
- Stream 2
- ICD9 Diagnostic Code
- (NOI) Nature of Injury Code
- Body Part
- Second Body Part
- Side of Body
- Left Right Both N/A