

Send this form to
appropriate insurer:

Fax # () -

Confirmation of Services Provided (Form NS-2a)

Use this form for accidents that occur on or after April 1, 2013.

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 (DDMMYYYY)		

Part 2 Primary Health Care Practitioner Information	Last Name	First Name	Date of Initial Assessment (DDMMYYYY)
	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 Nova Scotia Medical Services Insurance. Amounts listed on the table or in the attachment should be net of any reimbursement by Nova Scotia Medical Services 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 NS-1 and regarding my eligibility for accident benefits as outlined on Form NS-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 _____