

Workplace Safety & Insurance Board Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To: WSIB 200 Front Street West

OR Fax To: 416-344-4684 OR 1-888-313-73 Telephone: 416-344-1000 Toll Free: 1-800-387-0750

Vision Care Claim Form

Spaat Commission de la securite 200 Front Street West OR 1-888-313-7373 ITY: 1-800-387-0050 Toronto ON M5V 3J1												Г								
ONTARIO contre les accidents du travail Toronto ON M5V 3J1								Clain							m Number					
													L							
. Worker	Informati	ion					·									,.				
ast name F								First name					Initial							
urrent address Ci				City	ty			Province					Postal Code				Is this a new address?			
ome phone Work phone							,						Birth date (mm/dd/yyyy)							
3. Provide	r Informa	ation																		
rovider name									Star	Stamp or Label										
ddress: City Province								Postal Code					Business phone							
D	far Dan	: /D : - l		····· CNII N	(Donalda			et e Collection												
		air/Replace	ment Entitler		-	r to comple	ete 1	the following	·											
ngle Vision I	_ens(es)	yes	no	Hardex Le	ans(es)	yes		no	Tint		yes		no							
ther - specify	/ type		В	Sifocal - specify type																
escription:	Right E	Eye (OD)					Le	eft Eye (OS)												
as there dar	-	e to: ens(es):	left	right	both	no	one	Frame	y:	yes		no								
the replacer	he replacement frame similar to damaged frame? If not, is it of equal value? yes no yes no																			
ost of original lens(es)? Cost of replacement lens(es)? \$								Cost of original frames? Cost of replacement frames?												
otal cost wor	stal cost worker paid and is requesting reimbursement for?																			
rovider Sigr	nature							Date (mm/dd/yyyy)												
). Prescrip	Prescription Information - Optometrist to complete ONLY (if vision entitlement exists)																			
		Sphere	Cylinder	Axis	Prism	Add	٦	initial pr	rocorintian		¬ nro	oorin	tion o	unalaaaa		Dv.s	duplicate			
	Dimbé	Ophere	Cylinder	7013	1 113111	Add	\dashv	new pre			_ pres _ conf			unglasses s			acement (l	oss or		
New RX	Right Left						\dashv	□ safety g	glasses		lens				_		akage) `			
Old RX	Right			\longrightarrow			\dashv	-	เลrลcเ indicate any	y medi	cal cor	nditio	ons or	disease)						
Olu NA	Left						\dashv													
							\dashv	If claim is for contact lenses:												
Plastic [Type of right lens							Can visual acuity be restored to 20/70 ? 20/40 ?												
Hardened [☐ chem	Tint	nieniens					Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias or irregular corneal curvature? yes no Can visual acuity be improved by at least two lines on the Snelian chart over the best												
'	_	Oversi	ize: _			Can visual a possible vis	acuity be in sion with gla	nprove asses?	d by at	t leas	st two	lines on th	ne Sne no	lian c	hart over th	ie best				

E. Worker Declaration

Provider Signature

I hereby certify, that to the best of my knowledge, the information provided on this form is true, accurate and complete, and that the expenses listed were for myself and for my WSIB related claim. I agree to retain all original receipts and provide them to the WSIB with this form. For the expenses paid for by the WSIB, I will not request reimbursement from any other insurers/organizations. I also authorize the release of any information to the WSIB relating to the expenses and information listed on this form.

Signature Signature

Date (mm/dd/yyyy)

Date (mm/dd/yyyy)