wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

C972
HEARING LOSS SERVICES
HEARING LOSS AUTHORIZATION

WORKER DETAILS

		WCB Claim Number [Claim#]
Surname [Surname]	First Name and Initial [FirstName]	Date of Birth *(yyyy/mm/dd)*
Claimant Mailing Address:		

Clinic information

Provider Name	Billing Number			Date *(yyyy/mm/dd)*
Address Street	City/Town	Province	Postal Code	Telephone Number
Audiologist / Registered Hearing Aid Practitioner Providing Service	Clinic Email address			Fax Number

Request information

Is the product/service you are requesting covered under the WCB - Alberta Hearing Loss contract terms?	Yes ☐	No ☐
Request (required): Description of request		
Reason for request (required): Please describe reason/rationale for request		
Last supply date:		