ASCENT INTEGRATIVE HEALTH

WCB Initial Claim Form

Thank you for choosing Ascent for your care. Please provide the following information so we can efficiently process your claim,

Name: _____ Today's Date:_____

Date of Birth: _____ AHC # : _____

Claim Number:	
Date of Injury:	
Claim Representative:	
Name of Employer:	
Employer Address	
Employer Phone #:	

Please describe the nature of the injury:

(For office use only) Notes:

PLUS 15, Suite 310 840-7th Ave SW Calgary AB T2P 3G2 T: 403-262-1121 F: 403.262.1371