

**Return to:** Nova Scotia Department of Health & Wellness  
Third Party Liability  
P.O. Box 488  
Halifax, Nova Scotia B3J 2R8

Phone: (902) 424-6202  
Fax: (902) 424-2198



## Third Party Claim Notification Form

Name of Injured Party \_\_\_\_\_

Date of Birth \_\_\_\_\_

Nova Scotia Health Card Number (10 digits) \_\_\_\_\_

Briefly describe the injury(ies) sustained and how the incident happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Place of accident: \_\_\_\_\_

Date of accident: \_\_\_\_\_

Name of the hospital that provided treatment: \_\_\_\_\_

Did the injured party receive emergency treatment?                      Yes                      No

Was the injured party confined as a bed patient?                      Yes                      No

Were physiotherapy treatments provided?                      Yes                      No                      Ongoing

Name the hospital that provided physiotherapy treatments (if applicable) \_\_\_\_\_

Did the injured party require ambulance services?                      Yes                      No

Is the injured party covered under the Insured Prescription Drug Plan? \_\_\_\_\_

Have home-care services been provided or are anticipated in the future, for the injured party?      Yes              No

Was / Is care required in the home for special care?                      Yes                      No

Details of any long-term medical treatment, if currently available \_\_\_\_\_

\_\_\_\_\_  
Additional Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Lawyer for injured party: \_\_\_\_\_

\_\_\_\_\_

Form Completed By: \_\_\_\_\_