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)			
	Last Name First N						Date Of Birth (DI	NAGYVV)
Part 1	Last Name			FIIST Na	Name Date Of Bit			JWIWIT I I I )
Claimant Information	Date of Initial Assessment (DDMMYYYY)							
Part 2	Last Name First Na				ame Date of Initial			sessment (DDMMYYYY)
Primary Health Care Practitioner Information	Administrative Contact Name  Telephone Number (Include area code							
Part 3	Name of Adjunct Therapy Provider							
Adjunct Therapy	Address							
Provider Information	City, town	or county				Province	Postal Code	
(To be completed	Administrative Contact Name					Facility Name		
by Acupuncturist or Massage Therapist for reimbursement of Services)	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	Item	Date	Desc	cription	n of Service and Na	ame of Service Pro	ovider	\$ Amount
Treatments and Services	$\vdash$							
Additional sheets								
attached with claimant's signature	——————————————————————————————————————							
if information is not listed on this page								
	$\vdash$							
	$\vdash$							
						-		
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  Date							
Part 6	I confirm that I have provided the treatment, supplies or services identified on this form or have signed the attachments.							
Confirmation of Adjunct	Signature							
Therapy Provider								
	Date							
Part 7 Confirmation of								
Primary Health								
Care Practitioner								