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

200 Front Street West
Toronto ON M5V 3J1

WSIB Medication Reimbursement Form

Claim No.

In most cases, your claim related medications can be billed on-line by your pharmacist.
Provide the pharmacist with your claim number and ask that your prescription be processed through the WSIB on-line system.

Instructions for Completion

1. **Please print clearly in black ink.**
2. **Complete sections A, B, & C in full.**
3. **Send all original pharmacy receipts (not photocopies) with this form. Please write your claim number on each receipt.**

For further information, please see the back of this form.

A. Worker Information

Last name	First name	Initials

Current address	City	Province	Postal Code	New address? ☐ yes ☐ no

Home phone	Work phone	Birth date (dd/mm/yyyy)	Date of Accident (dd/mm/yyyy)
( )	( )		

B. Medication Information (found on prescription label)

I am claiming repayment for the following medication(s) I purchased:

Drug Name	Prescription No.(Rx) Drug Identification Number (DIN)	Name of Prescribing Physician	Pharmacy Name Telephone No.	Quantity	Amount Taken each time	How often per day	Date Drug Dispensed dd	mm	yyyy	Total Cost of Drugs*	Total Amount I Paid**	WSIB Use Only
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	
	Rx No. DIN		Pharmacy Name Telephone: ( )							$	$	

* Total cost including dispensing fee. ** Amount you paid the pharmacy and want WSIB to reimburse you.

C. Worker Declaration

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

Signature	Date (dd/mm/yyyy)

Instructions to Worker

Incomplete information, not signing and dating the form, or not providing original receipts may result in the form being returned to you and /or delay the processing of your payment.

1. Your WSIB claim number **must** be included on this form.
2. Original medication receipts **(not photocopies, faxes or pharmacy printouts)** must be sent with this form. We encourage you to send in your receipts immediately.
3. WSIB will not return original receipts.
4. WSIB will not accept requests for co-payments for medication paid by the Ministry of Health or any other insurer.
5. **Quantity** of the drug dispensed refers to the total amount provided to you (e.g. 250 ml. or 50 tablets, etc.).
6. **Amount taken each time** is the dosage of the drug dispensed each time you take it (e.g. 15 ml. or 2 tablets, etc.).
7. **How often per day** is the number of times you take the drug (e.g. 2 times /day, one at suppertime, etc,).
8. **Dispensing Date** is the date the drug was provided to you (dd-mm-yyyy).
9. For **Total Cost of Drugs**, enter the total cost of the medication you need. This should include both the dispensing fee and the cost of the medication itself.
10. **Total amount I Paid** is the amount you actually paid to the pharmacist and are asking the WSIB to reimburse you for.

You may submit your form directly to your local WSIB office.
Additional forms are available from your Pharmacist, your local WSIB office or by calling the Drug Information Hot Line, Toll Free at **1-800-655-4631.**