WSIB Ontario | Vision care claim form

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

A. Worker information

Last name	First name	Initial

Current address	City	Province	Postal code	Is this a new address ☐ Yes ☐ No

Home Phone	Work phone	Birth date (mm/dd/yyyy)

B. Provider information

Provider name	Stamp or label

Address	City	Province	Postal code	Business phone

C. Damage for repair/replacement entitlement ONLY (Provider to complete the following)

Single vision lens(es) ☐ Yes ☐ No	Hardex Lens(es) ☐ Yes ☐ No	Tint ☐ Yes ☐ No

Other - specify type	Bifocal - specify type	Prescription: Right Eye (OD)	Left Eye (OS)

Was there damage done to: Lens(es): ☐ Left ☐ Right ☐ Both ☐ None	Frame: ☐ Yes ☐ No

Is the replacement frame similar to damaged frame? ☐ Yes ☐ No	If not, is it of equal value? ☐ Yes ☐ No

Cost of original lens(es)? $	Cost of replacement lens(es)? $	Cost of original frames? $

Cost of replacement frames? $	Total cost worker paid and is requesting reimbursement for? $

Name	Provider signature	Date (mm/dd/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

D. Prescription information - Optometrist to complete ONLY (if vision entitlement exists)

		Sphere	Cylinder	Axis	Prism	Add
New RX	Right					
	Left					
Old RX	Right					
	Left					

Plastic ☐
Hardened ☐ chem ☐ heat

Type of right lens

Type of left lens

Tint

Oversize: mm

☐ initial prescription ☐ prescription sunglasses
☐ Rx duplicate ☐ new prescription
☐ contact lenses ☐ replacement (loss or breakage)
☐ safety glasses ☐ lenses only ☐ post cataract
☐ other (indicate any medical conditions or disease)

If this claim is for contact lenses:

Can visual acuity be restored to 20/70 ☐ ? 20/40 ☐ ?

Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias or irregular corneal curvature? ☐ Yes ☐ No

Can visual acuity be improved by at least two lines on the Snelian chart over the best possible vision with glasses? ☐ Yes ☐ No

Name	Provider signature	Date (mm/dd/yyyy)

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E. 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 the expenses listed were for myself and for my WSIB related claim. I agree to retain all original receipts and provide them to the WSIB with this form. For the expenses paid for by the WSIB, I will not request reimbursement from any other insurers/organizations. I also authorize the release of any information to the WSIB relating to the expenses and information listed on this form.

Name	Signature	Date (mm/dd/yyyy)

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Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.