



# Treatment Plan — Occupational Therapy

Return To ICBC  
PO BOX 2121, STN TERMINAL  
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222



CLIENT INFORMATION			
CLAIM NUMBER	FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)

PRACTITIONER INFORMATION		
CLINIC NAME	VENDOR NUMBER	
PRACTITIONER FIRST NAME	PRACTITIONER LAST NAME	PRACTITIONER NUMBER

TREATMENT PLAN INFORMATION	
DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF TREATMENT PLAN (dd/mmm/yyyy)
PRACTITIONER/THERAPIST TYPE (select one from list)	

1. Recommended Treatment	
NUMBER OF TREATMENT HOURS (Completed to Date)	NUMBER OF ADDITIONAL TREATMENT HOURS (Requested)
NUMBER OF APPROVED HOURS REMAINING	ANTICIPATED END DATE FOR RECOMMENDED TREATMENT

Your contact preference?  Email  Phone

Provide an email address or phone number in case we need to contact you	
EMAIL	PHONE

This form must be completed in full. Incomplete Treatment Plans may result in delays and impact treatment funding approval.

I certify that the information provided is true and correct to the best of my knowledge and that this Treatment Plan has been completed by a treating therapist.

Providing false or misleading information may result in the cancellation of your vendor number, and ICBC may seek financial restitution and/or take legal action.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.