**MEDICAL INVOICE**

|  |  |
| --- | --- |
|  | WCB Claim Number |
|  | Personal Health number

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |

 |
| Worker’s Last Name First Name Initial | Date of Birth \_\_\_/\_\_\_/\_\_\_\_ |
|  Mailing Address: City/Town: Post code: |
| Telephone Number Gender: □ Male □ Female Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_  |
| Part of Body | Side of Body | Nature of injury |
| Name of Referring Physician |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Service | Health Service Code | Diagnostic Code | Modifier | Skill Code | Calls | Encounter | Fees submitted |
|  |  |  |  |  |  |  | $ |
|  |  |  |  |  |  |  | $ |
|  |  |  |  |  |  |  | $ |
|  |  |  |  |  |  |  | $ |
|  |  |  |  |  |  |  | $ |
|  |  |  |  |  | Total Amount Billed: |  | $ |

|  |  |  |
| --- | --- | --- |
| Dialing Number | Contact ID | Facility Type |
| Name and Address to whom fees payable | Signature | Printed Name |
|  | Telephone Number | Fax number |
|  | Providers reference number | Date |