**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 |