



This invoice must be submitted within 90 days of the date of service. Please **FAX** or mail completed form to WorkSafeBC as indicated below. **All fields with* are required for payment to be processed.** Failure to provide this information may result in processing delays. Please complete all other fields (if possible). Incomplete invoices may be returned for resubmission.

PAYMENT SERVICES
Phone 604 276-3085
Toll-free 1 888 422-2228

FAX
604 233-9777
Toll-free **1 888 922-8807**

MAIL
Payment Services, WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Payment information	Invoice number	Invoice date (yyyy-mm-dd)	
	Provider name	Practitioner number*	Payee number*
	Mailing address for payment	City	Province Postal code*
	Telephone number (please include area code)	Fax number (please include area code)	

Service recipient information (worker or other person who received service)

Service recipient last name*	Service recipient first name*	Gender* Male <input type="checkbox"/> Female <input type="checkbox"/>
Service recipient date of birth* (yyyy-mm-dd)	Service recipient personal health number* (CareCard number)	
Date of injury* (yyyy-mm-dd)	WorkSafeBC claim number (if available)	

Injury information

Diagnostic code (ICD9)*	Side of body code*	Body part code*	Nature of injury*
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Service information (Please select ONE only) Chiropractic Massage therapy Physiotherapy

Service location code*	Date of service* (yyyy-mm-dd)	Fee code*	Service description*	Number of service units*	Cost* (cost per unit)	Line item amount*

Invoice total* \$

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.