



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**  
**604 276-3195**  
Toll-free **1 888 922-3299**

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

<b>Payment information</b>		Invoice number	Invoice date* (yyyy-mm-dd)	
Contract ID	Payee name	Payee number*	Facility number, if applicable	
Referred by facility (facility number)		Referred by facility (name of facility)		Practitioner name
Practitioner number (may be the same as payee number)		Referred by practitioner (practitioner number)		Referred by practitioner (name of practitioner)
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*
Service recipient date of birth* (yyyy-mm-dd)	Service recipient personal health number* (CareCard number)
WorkSafeBC claim number (if available)	Gender* Male <input type="checkbox"/> Female <input type="checkbox"/>

**Injury information**

Date of injury* (yyyy-mm-dd)	Diagnostic code* (ICD-9 code)	
Side of body* Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Not applicable <input type="checkbox"/>	Body part code*	Nature of injury code*

**Service information**

Service location code*	Date of service* (yyyy-mm-dd)	Fee code*	Fee description*	Number of services* (number of units)	When applicable			Line item amount* (fee)
					After hours indicator (X)	Time call started (hh:mm)	Time call ended (hh:mm)	

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.

Invoice total amount\*