



# RESIDENTIAL CARE SERVICES INVOICE

Please **FAX** 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.

Number of pages sent of
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If additional invoicing space is required to list all items you wish to bill for, please submit a second invoice form (83D103).

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

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

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

Invoice number*	Invoice date* (yyyy-mm-dd)
Contract ID*	Service location code

**Payment information**

Provider (agency/payee) name*	Payee number*	HST registration 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*
Service recipient date of birth* (yyyy-mm-dd)	Service recipient personal health number (CareCard number)
WorkSafeBC claim number*	Date of injury (yyyy-mm-dd)

**Service information**

Date of service* (yyyy-mm-dd)	Fee item code*	Fee description*	(A) Number of days* (number of units)	(B) Per diem amount* (cost per unit)	(A) x (B) Line item amount* (not including taxes)	HST (If charged)	Line item total* (including taxes)	Comments
<b>Invoice total*</b>							<b>\$</b>	

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.