WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

SURGICAL FACILITY OR MEDICAL IMAGING FACILITY INVOICE

This invoice must be submitted within 90 days of the date of service. **All fields with * are required for payment to be processed**. Failure to provide this information may result in processing delays or in non-payment. All other fields to be completed (if possible).

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

Number of pages sent

Invoice date*	Invoice number	Contract ID

Payment information

Payee name*			
Payee number*	Date of approval for non-VSC surgery *(yyyy-mm-dd)*		
Surgical or medical imaging facility name			
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 ☐ Female ☐	Date of birth* *(yyyy-mm-dd)*
Personal health number* *(CareCard number)*	WorkSafeBC claim number*

Injury information

Date of injury* *(yyyy-mm-dd)*	Diagnostic code* *(ICD-9 code)*	
Side of body Left ☐ Right ☐ Bilateral ☐ Not applicable ☐	Body part code	Nature of injury code

Service information

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

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.