



Complete and **FAX** this **INVOICE** to WorkSafeBC using the fax number provided below. All fields with \* are required.

**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

Date of invoice (yyyy-mm-dd)
Invoice number

**Service recipient information**

Client last name* (worker last name)		Client first name* (worker first name)	
Client date of birth (yyyy-m-dd)		Client personal health number (CareCard number)	
WorkSafeBC claim number*	Date of injury (yyyy-mm-dd)	Client phone number (include area code)	

**Therapist information**

Therapist name	Therapist contact
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**Supplier/vendor information**

Payee name		Payee number*	HST registration number	
Mailing address for payment		City	Province	Postal code*
Phone number* (include area code)	Fax number* (include area code)	Name of representative*		

**Service information**

Date of service/delivery* (yyyy-mm-dd)	Fee code*	Description* (include item/part number)	Number of items* (numbers of units)	Cost per unit*	Line item amount* (not including taxes)	Discount %	Line item discounted amount (not including taxes)	HST (if charged)	Line item total* (including taxes)

