



# SUMMARY INVOICE FOR EXPEDITED SURGERY

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.

**Please note:** Submit one invoice per patient. Only one post-operative visit within 42 days of surgery is billable using fee item 19931 via Teleplan.

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

**FAX**  
**604 244-6292**

**MAIL**  
Payment Services, WorkSafeBC  
PO Box 94460 Stn Main  
Richmond BC V6X 8V6

**Payment information**

Date surgery booked (yyyy-mm-dd)	Date surgery approved (yyyy-mm-dd)	Invoice date (yyyy-mm-dd)	Date of service* (yyyy-mm-dd)	
Specialist's name		Practitioner number*	Payee number*	
Mailing address for payment		City	Province	Postal code*
Name of anesthetist		Name of assistant		Facility (service location)

**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)	
WorkSafeBC claim number*	Date of injury* (yyyy-mm-dd)	

**Service details**

Side of body*	Body part code*	Diagnostic code* (ICD9)	Fee code*	Nature of injury*	Surgical procedure* (fee description)	Time* (hours)	Total fee amount
Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A <input type="checkbox"/>							
Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A <input type="checkbox"/>							
Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A <input type="checkbox"/>							
<b>Total hours</b>							
<b>Total payable</b>						\$	

Signature*  (MD)
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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.

