WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

COMMUNITY OCCUPATIONAL THERAPY INVOICE

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

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

Number of invoice pages submitted
One ☐ Two ☐

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

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

Payment information

Provider name		Payee number*	
Mailing address for payment	City	Province	Postal code*
Telephone number *(please include area code)*	Fax number *(please include area code)*		

Service information

Date of service* *(yyyy-mm-dd)*	Travel info* *(if applicable)* Origin city/site	Destination city/site	(✓) if round trip	Fee code*	Fee description* *(service type)*	Number of units	Cost per unit* *(or flat fee)*	Line item amount* *(not including taxes)*	HST *(if charged)*	Line item total* *(including taxes)*
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								Invoice total (page 1)		

Workers' Compensation Board of B.C.

WORKSAFE BC
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Community Occupational Therapy Invoice *(continued)*

Worker last name	First name	Invoice number	WorkSafeBC claim number

Date of service* *(yyyy-mm-dd)*	Travel info* *(if applicable)*			Fee code*	Fee description* *(service type)*	Number of units	Cost per unit* *(or flat fee)*	Line item amount* *(not including taxes)*	HST *(if charged)*	Line item total* *(including taxes)*
	Origin city/site	Destination city/site	(✓) if round trip							
									Page 1 total	
									Invoice total*	

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.