

Invoice ASTD Services

Fax with report and BSRS fax cover sheet to:
WCB at 1-888-669-9970

Worker Information

NAME (last, first, initial)	WCB CLAIM NUMBER
DATE OF INJURY (yy/mm/dd)	REFERRAL DATE (yy/mm/dd)

Provider Information

PROVIDER NAME	PROVIDER ADDRESS
PAYEE NUMBER	
INVOICE DATE (yy/mm/dd)	
INVOICE NUMBER (Maximum 5 digits)	PROVIDER PHONE NUMBER

Billing Information

Date (s) (yy/mm/dd)	Service Provided	Participation Days (if applicable)	Fee

Comments:

If this fax is received in error, please contact WCB Health Care Services at (604) 232 -7787