# MEDICAL SUPPLIES INVOICE

**Please print clearly or type**

Worker’s:  
Surname  
First Name  
Initial  
Personal Health Number  
Date of Birth  
(Year / Month / Day)  

Address:  
Street  
City/Town  
Province  
Postal Code  
Date of Accident  
(Year / Month / Day)  

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<tr>
<th>Date Received</th>
<th>Quantity</th>
<th>Type and Description</th>
<th>Amount</th>
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**Total Amount Billed:** $________

Supplies received by: ______________________  
Patient’s Signature: ______________________

Name and address of Practitioner to whom fee is payable (please print):

Name: ______________________  
Address: ______________________  
Telephone Number: (______) ______-______

WCB Billing Number: ______________________

Contract ID: ______________________  
(if applicable)

Skill Code: ______________________  
(if applicable)

**This form must have a WCB Claim Number**

**THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.**

C - 569 REV MAY 99  
Des: Dates Received  
PART 1 - WCB  
PART 2 - PRACTITIONER