Workers' Compensation Board
Alberta

MEDICAL SUPPLIES INVOICE

P.O. BOX 2415
EDMONTON, AB T5J 2S5

FAX: (780) 427 - 5863

Please print clearly or type

WCB Claim Number

Worker's: *Surname* *First Name* *Initial*

Personal Health Number

Address: *Street*

Date of Birth *(Year / Month / Day)*

City/Town *Province* *Postal Code*

Date of Accident *(Year / Month / Day)*

Date Received *(Year / Month / Day)*	**Quantity**	**Type and Description**	**Amount**
			$.
			$.
			$.
			$.
			$.
			$.
			$.
			$.

Total Amount Billed: $.

Supplies received by: _____

Patient's Signature:

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

WCB Billing Number: _____

Contract ID: _____
(if applicable)

Skill Code: _____
(if applicable)

Telephone Number: ( ) _____

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.