wcb | Saskatchewan Workers' Compensation Board

200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll-free fax: 1.888.844.7773

PHYS

Reference # or Invoice # Original

WCB Claim Number

Name of Clinic _____ **Provincial Health No.** 123 456 789

Clinic # SK 0000 **Caregiver #** _____ **Social Insurance #** _____

Phone # (306) 716-5899 **Fax #** (306) 668-1309 **Date of Birth:** 01 / 05 / 1980 (DD MM YYYY)

Physician's Name, Address, Postal Code

Worker's Name, Address, Postal Code

JANE DOE
123 STREET
ANYTOWN SK S4P 4L1

Date of Injury 16 / 05 / 2017 (DD MM YYYY) **Off Work** ☐ Yes ☒ No

Part of Body back

Diagnosis strain

Employer Name ABC Company

Billing Period:

From 01 / 10 / 2017 (DD MM YYYY)

To 31 / 10 / 2017 (DD MM YYYY)

Start Date:

Primary _____ (DD MM YYYY)

Secondary _____ (DD MM YYYY)

Tertiary _____ (DD MM YYYY)

Fee Descriptor	Fee Code	# of Units	Est. Cost
Occupational Therapy Initial Assmnt & Report	900	1	$94.68
Occupational Therapy Subsquent Visit & Report	901	5	$230.40
Occupational Therapy Conference	905	1	$118.82
Occupational Therapy Rtw Arrangements	902	2	$248.26
		Total	$692.16

Comments _____

* indicates the fee amount has been overridden.
This invoice is subject to WCB review

wcb | Saskatchewan Workers' Compensation Board

200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll-free fax: 1.888.844.7773

PHYS

Reference # or Invoice # Adjustment/Addition

WCB Claim Number

Name of Clinic _____ **Provincial Health No.** 123 456 789

Clinic # SK 0000 **Caregiver #** _____ **Social Insurance #** _____

Phone # (306) 716-5899 **Fax #** (306) 668-1309 **Date of Birth:** 01 / 05 / 1980 (DD MM YYYY)

Physician's Name, Address, Postal Code

Worker's Name, Address, Postal Code

JANE DOE
123 STREET
ANYTOWN SK S4P 4L1

Date of Injury 16 / 05 / 2017 (DD MM YYYY) **Off Work** ☐ Yes ☒ No

Part of Body back

Diagnosis strain

Employer Name ABC Company

Billing Period:

From 01 / 10 / 2017 (DD MM YYYY)

To 31 / 10 / 2017 (DD MM YYYY)

Start Date:

Primary _____ (DD MM YYYY)

Secondary _____ (DD MM YYYY)

Tertiary _____ (DD MM YYYY)

Fee Descriptor	Fee Code	# of Units	Est. Cost
Occupational Therapy Initial Assmnt & Report	900	1	$94.68
Occupational Therapy Subsquent Visit & Report	(901)	(5)	($230.40)
Occupational Therapy Conference	905	1	$118.82
Occupational Therapy Rtw Arrangements	(902)	(2)	($248.26)
		Total	$692.16

Comments

901 4 $184.32

902 1 $124.13

903 1 $118.82

Total $427.27

* indicates the fee amount has been overridden.

This invoice is subject to WCB review