Saskatchewan Workers' Compensation Board
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Regina SK S4P 4L1
wcbsask.com

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Toll free fax: 1.888.844.7773

PHYS

Click on any field to start editing.

Reset Form

Reference or invoice: _____

WCB claim number: _____

Name of clinic: _____ **Provincial Health Number:** _____

Clinic number: _____ **Billing number:** _____ **Date of birth:** _____ MM/DD/YYYY

Phone: _____ **Fax:** _____

Care provider's name, address, postal code

Worker's name, address, postal code

Date of injury: _____ MM/DD/YYYY

Part of body: _____

Billing period: _____ MM/DD/YYYY **to** _____ MM/DD/YYYY

Primary date	Secondary date	Tertiary date
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY

Treatment date MM/DD/YYYY	Description	Fee code	Units	Explanatory code	Cost
				Total	

Comments: _____

When writing to the WCB, please print name and claim or firm number.