



Saskatchewan
Workers'
Compensation
Board

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THER

Click on any field to start editing.

Reference or invoice: _____

WCB claim number: _____

Name of clinic: _____	Provincial Health Number: _____
Clinic number: _____	Billing number: _____
Phone: _____	Date of birth: _____ <small>MM/DD/YYYY</small>
Fax: _____	
<i>Care provider's name, address, postal code</i>	<i>Worker's name, address, postal code</i>

Date of injury: _____
MM/DD/YYYY

Part of body: _____

Treatment date <small>MM/DD/YYYY</small>	Description	Fee Code	Units	Explanatory Code	Cost
Total					

Comments: _____

