Saskatchewan Workers' Compensation Board

Health Care Services
200 – 1881 Scarth Street
Regina, SK S4P 4L1

Phone: 306.787.4339
Toll free: 1.800.667.7590 ext. 4339
Fax: (306) 787-2428
Toll free Fax: 1.866.331.3036
Attn: Accreditation

Accreditation Request – Primary Level Services

Your professional association has negotiated an agreement with the Workers' Compensation Board. A copy of the Agreement is enclosed. Your treatment of injured workers, and submission of billings to the Board for such treatment, will constitute your acknowledgement and acceptance of the Agreement.

Name of care provider: _____

Type of service provided: _____

Name of clinic(s) at which you provide services (it is important that all clinics are listed):

1. Payee: _____
   Address: _____
   Phone: _____ Fax: _____

2. Payee: _____
   Address: _____
   Phone: _____ Fax: _____

3. Payee: _____
   Address: _____
   Phone: _____ Fax: _____

Association you are registered/licensed with: _____

Qualifications: Verification of current license and, attach proof of credentials. (i.e. Copy of your degree, transcripts if you are a psychologist.).

Please indicate with an "✓":

☐ I require an individual billing number, as I am an independent care provider.

☐ Payee name **(**please print): _____

☐ I require a WCB billing number for each of the above clinics.

☐ My clinic already has a WCB billing number.

☐ I no longer practice at the following clinics, therefore my accreditation can be discontinued:

1. _____
2. _____
3. _____

I verify that the information provided above is accurate and correct to the best of my knowledge. My signature below confirms that I agree to abide by all current practice standards and requirements as set out by WCB and my professional association. I understand that I am required to notify the WCB if I cannot abide by future standards and requirements, and my accreditation and billing number will be withdrawn.

Signature _____ Date (dd/mm/yy)