

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: (780) 427-5863
1-800-661-1993

C641
HOME HEALTH CARE SERVICES
Invoice

Please print clearly or type.

WCB Claim Number		Personal Health Number	Date of Accident (yyyy/mm/dd)
Worker's Surname	First Name	Initial	Date of Birth (yyyy/mm/dd)
Address	City/Town	Province	Postal Code Telephone Number ()

NOTE: Billing Start Date and End Date must be within the same calendar month

Billing Start Date (yyyy/mm/dd):	Billing End Date (yyyy/mm/dd):
----------------------------------	--------------------------------

RN	# of Hours	Rate	Amount
Services		\$63.52	
Stat Holiday		\$95.28	
Cancellation		\$63.52	
Subtotal A			

LPN	# of Hours	Rate	Amount
Services		\$40.17	
Stat Holiday		\$60.26	
Cancellation		\$40.17	
Subtotal B			

HCA	# of Hours	Rate	Amount
Services		\$31.52	
Stat Holiday		\$47.28	
Cancellation		\$31.52	
Subtotal C			

RN Coordination	# of Hours	Rate	Amount
Services (1 Hour per 180 Hours of Service)		\$63.52	
Subtotal D			

RN Assessment	# of Hours	Flat Rate	Amount
Assessment (Includes First 3 Hours)	N/A	\$140.33	
RN Assessment	# of Hours	Rate	Amount
Assessment (Maximum of 4 Additional Hours)		\$63.52	
Reassessment (Maximum of 3 Hours)		\$63.52	
Subtotal E			

Travel Time*	# of Hours	Rate	Amount
RN		\$63.52	
LPN		\$40.17	
HCA		\$31.52	
Mileage*	Distance (kilometers)	Rate	Amount
RN/LPN/HCA		\$0.49	
Subtotal F			

* Prior authorization is required

Miscellaneous Expenses* (Receipts are required)		
Service Date (yyyy/mm/dd)	Description	Amount
Subtotal G		

* Prior authorization is required

Add Subtotals A through G

Total Amount Billed \$

Name and Address to Whom Fee is Payable (print) WCB Billing Number: TOP NOP: MS 06	Signature	
	Print Name	
	Telephone Number ()	Fax Number ()
	Provider Reference Number	Date (yyyy/mm/dd)

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.