

INVOICE CORRECTION

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

Worker's name: <i>surname</i>			<i>first name</i>	<i>initial</i>	Claim number
Address: <i>street</i>					Personal health number
			<i>city/town</i>	<i>province</i>	Date of birth (yyyy/mm/dd)
			<i>postal code</i>		
Telephone number	Date of accident (yyyy/mm/dd)		Contract number	Skill code	

Date of Service (yyyy/mm/dd)	Fee Code	Units	Amount
1. Was:			€
_____	_____	_____	_____
Should be:			€
_____	_____	_____	_____
2. Was:			\$
_____	_____	_____	_____
Should be:			\$
_____	_____	_____	_____
3. Was:			€
_____	_____	_____	_____
Should be:			€
_____	_____	_____	_____

Additional comments:

Name and address to whom fee is payable (<i>please print</i>):	Provider's signature:	
	Provider's name:	
	Date (yyyy/mm/dd):	Telephone number:
WCB billing number:		

THIS FORM MUST HAVE A WCB CLAIM NUMBER.