Workers' Compensation Board
Alberta

HC-430
WCB Health Care Services
Home Health Care Services

RECEIPT OF SERVICES

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 ( )
Provider's Name			Provider File Number

Date of Service *(yyyy/mm/dd)*	Hours of Services	Employee's Name	Service Code	Employee's Signature	Worker's Signature

Service Codes: ***1 - RN Coordination*** ***2 - RN*** ***3 - LPN*** ***4 - PCA***

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131 Airport Road, Edmonton, AB T5G 0W6, Phone: (780) 498-3219