



Workers' Compensation Board

Alberta

ACUPUNCTURE INVOICE

Box 2415, Edmonton
 Alberta T5J 2S5
 Fax (780) 427-5863
 1-800-661-1993

Please print clearly / or type

| |
|------------------------|
| WCB Claim Number |
| Personal Health Number |

| | | | | |
|-------------------|------------------|----------------------|---------------|----------------------|
| Patient's Surname | First Name | Initial | Date of Birth | (Year / Month / Day) |
| Address Street | City/Town | Province | Postal Code | |
| Telephone Number | Date of Accident | (Year / Month / Day) | Part of Body | Type of Injury |

| Date of Service (Year / Month / Day) | Health Service Code | Diagnostic Codes (Year / Month / Day) | | Fee Submitted |
|---|---------------------|--|--|---------------------|
| 1. | | | | \$ |
| 2. | | | | \$ |
| 3. | | | | \$ |
| 4. | | | | \$ |
| 5. | | | | \$ |
| 6. | | | | \$ |
| 7. | | | | \$ |
| 8. | | | | \$ |
| 9. | | | | \$ |
| 10. | | | | \$ |
| 11. | | | | \$ |
| 12. | | | | \$ |
| 13. | | | | \$ |
| 14. | | | | \$ |
| 15. | | | | \$ |
| 16. | | | | \$ |
| 17. | | | | \$ |
| 18. | | | | \$ |
| 19. | | | | \$ |
| 20. | | | | \$ |
| <input type="checkbox"/> Continued Treatment <input type="checkbox"/> Final Treatment | | | | Total Amount Billed |

This document MUST be accompanied by a Progress or Discharge Report and must have a WCB Claim Number.

| | | |
|---|---------------------------|------------------|
| Name and address to whom fee is payable: (please print) | Signature: | |
| | Print Name: | |
| | Date (Year / Month / Day) | Telephone Number |

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