Workers' Compensation Board
Alberta

C537
PROSTHETIC AND ORTHOTIC SERVICES
Invoice

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

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 ( )

Date of Service *(yyyy/mm/dd)*

DEVICES/SERVICES *(if you require more space please use back of page)*

Fee Code	Description	Quantity	Unit Cost	Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

Total Amount $

If an unspecified price item/service (eg. Unlisted device) is used please also complete and submit a C537A form.

I, _____ verify that I have received the equipment as listed on this invoice. (Workers' Signature)	Date of Authorization *(yyyy/mm/dd)*	
Name and address to whom fee is payable (please print).	Provider Signature	
	Print Name	
	Telephone Number ( )	Fax Number ( )
WCB Billing Number:	Date *(yyyy/mm/dd)*	Provider Invoice Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.
INVOICE MUST BE SUBMITTED WITHIN 6 MONTHS OF SERVICE TO BE ELIGIBLE FOR PAYMENT.