

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

Please print clearly or type.

		WCB Claim Number	Date of Accident
Surname	First Name and Initial		Date of Birth (yyyy/mm/dd)
Address	City/Town	Province	Postal Code
Telephone Number	Part of Body	Type of Injury	

Date of Service (yyyy/mm/dd)	Health Service Code (see legend below)	Type of Service	Fee Submitted
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
<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 (print)	Signature	
	Print Name	
	Telephone Number	Fax Number
	Provider Reference Number	Date (yyyy/mm/dd)
WCB Billing Number:		

SERVICE LEGEND

DESCRIPTION	SERVICE CODE	RATE (APR 1, 2019 – DEC 31, 2020)
Acupuncture Assessment	ACU01	\$46.93
Acupuncture Treatment	ACU02	\$37.80

BILLING RULES

- All invoices must be submitted within six (6) months of date of service.
- Do not invoice report fees; reports fees are paid automatically.

**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.**