Workers' Compensation Board Alberta

P.O. Box 2415,
Edmonton, AB T5J 2S5
Fax **780-427-5863**
1-800-661-1993

C1138
SHORT TERM HOME ASSISTANCE INVOICE

Please print clearly or type

WCB Claim Number:

Claimant's: *Surname* *First Name* *Initial*

Date of Birth *(Year / Month / Day)*

Address: *Street*

Date of Accident *(Year / Month / Day)*

City/Town *Province* *Postal Code*

Date of Service *(Year / Month / Day)*	*Description of Service*	*Hourly Rate*	*Hours Billed*	*Total Cost*

Name and address to whom fee is payable: (please print)

Provider's Signature:

Date *(Year / Month / Day)*

Print Name:

Fee Code SSF08

Telephone Number

Fax Number

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