Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
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1-800-661-1993

C019
PHYSICAL THERAPY SERVICES
Invoice

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 Street	City/Town	Province	Postal Code	Telephone Number
				( )

Service Items

Date of Service *(yyyy/mm/dd)*	Health Service Code	Description	Quantity	Rate per Unit	Fee Submitted
				Total Amount Billed	

Sundry Items

Date of Service *(yyyy/mm/dd)*	Health Service Code	Description	Quantity	Fee Submitted
			Total Amount Billed	

Name and Address to Whom Fee is Payable	Provider Name:	
	Print Name	
WCB Billing Number:	Telephone Number ( )	Fax Number ( )
	Provider Reference Number	Date *(yyyy/mm/dd)*

NOTE: PLEASE SEE REVERSE FOR SERVICE LEGEND

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