

THER

TREATMENT BILLING SUMMARY
FOR
MONTHLY/BIMONTHLY BILLINGS

WCB CLAIM #: _____

CARE PROVIDER BILLING #: _____

SERVICE PROVIDER: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

CLIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PERSONAL HEALTH #: _____ DATE OF INJURY: _____

AREA OF INJURY: _____

EMPLOYER'S ADDRESS: _____

PRIMARY START DATE: _____ BILLING PERIOD: _____

SECONDARY START DATE: _____ TERTIARY START DATE: _____

FEE DESCRIPTOR	LEVEL P,S,T	FEE CODE	NUMBER OF TREATMENTS OR UNITS IN BILLING PERIOD	TOTAL
TOTAL OF ALL SERVICES FOR BILLING PERIOD: _____				