

## ACCREDITATION REQUEST – PRIMARY LEVEL SERVICES

Your professional association has negotiated an Agreement with the Workers' Compensation Board, the Association and Individual Members like you. A copy of the Agreement is enclosed. Your treatment of injured workers, and submission of billings to the Board for such treatment, will constitute your acknowledgement and acceptance of the Agreement.

Name of Care Provider: \_\_\_\_\_

Type of Service Provided: \_\_\_\_\_

Name of Clinic(s) at which you provide services (it is important that all clinics are listed):

1. Payee: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

2. Payee: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. Payee: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

4. Payee: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Association you are registered/licensed with:** \_\_\_\_\_

**Qualifications:** (attach proof of credentials (including copy of your degree, if applicable) and verification of current registration).

**Please indicate with an "X":**

\_\_\_\_\_ I require an individual billing number, as I am an independent care provider.

\_\_\_\_\_ Payee name (please print): \_\_\_\_\_

\_\_\_\_\_ I require a WCB billing number for each of the above clinics.

\_\_\_\_\_ My clinic already has a WCB billing number.

I verify that the information provided above is accurate and correct to the best of my knowledge. My signature below confirms that I agree to abide by all current practice standards and requirements as set out by WCB and my professional association. I understand that I am required to notify WCB if I cannot abide by future standards and requirements, so that my accreditation and billing number can be withdrawn.

**Signature** \_\_\_\_\_ **Date** (dd/mm/yy) \_\_\_\_\_