Saskatchewan Workers' Compensation Board

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CHRO

Click on any field to start editing.

Chiropractors Billing Form

WCB claim number: _____

Worker's name: _____ **Date of birth:** _____

Worker's Address: _____

Provincial Health number: _____ **Date of injury:** _____

Social Insurance number: _____ **Off work:** ☐ **Yes** ☐ **No** **Estimated RTW date:** _____

Employer's name: _____

Employer's address: _____

Clinic number: _____ **Doctor number:** _____ **Phone number:** _____

Diagnosis:

Treatment or remarks:

Treatment Date (DD/MM/YY)	**Fee Code**	**Fee Amount**	**Total**
Total amount $: _____ Final treatment: ☐ Yes ☐ No			

Signature: _____

Updated: 08/16

Complete and legible information will assist us in processing your payment.

MISSION: ZERO