



Monthly/Bi-monthly Treatment Billing Summary

PHYS

Click on any field to start editing.

WCB claim number: _____

Care provider billing number: _____

Service provider: _____

Address: _____

Phone number: _____ Fax number: _____

Injured worker's name: _____ Date of birth: _____

Address: _____

Provincial Health number: _____ 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:				