



## 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
<b>Total of all services for billing period:</b>				