



THER

Treatment Billing Summary for Monthly/Bi-Monthly Billings

WCB Claim No.: _____

Care Provider Billing No.: _____

Service Provider: _____

Address: _____

Care Provider Phone No.: _____ Care Provider Fax No.: _____

Client's Name: _____ Date of Birth: _____

Address: _____

Personal Health No.: _____ 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: _____				

