Saskatchewan Workers' Compensation Board

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Accreditation request – mental health primary level services

Your treatment of injured workers, and submission of billings to the WCB 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: ____________________

Saskatchewan regulatory authority you are registered/licensed with: ____________________

Qualifications: Attach copy of current license, Authorized Practice Endorsement (APE) certificate, active accredited APE support agreement if applicable and proof of credentials (see website for full list of requirements at wcbsask.com/mental-health)

Please indicate with an "✓":

- ☐ I require an individual billing number, as I am an independent care provider.
- ☐ I require a WCB billing number for each of the above clinics.
- ☐ My clinic already has a WCB billing number.
- ☐ I no longer practice at the following clinics. Therefore, my accreditation can be discontinued:

  1. ____________________
  2. ____________________
  3. ____________________

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 the WCB. I understand that I am required to notify the WCB if I cannot abide by future standards and requirements, and my accreditation and billing number will be withdrawn.

____________________ ____________________

Signature of provider Date