Saskatchewan Workers' Compensation Board

200 - 1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

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Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

Click on any field to start editing.

WME

Reset Form

Worker's Medical Expense Statement

Name, address, postal code

WCB claim number: _____

If you require reimbursement for medical expenses, please complete and return this form.

1. Please fully complete all required fields.
2. Attach original or copies of original receipts for all expenses being claimed.
3. Please use a separate sheet if additional space is required.

Incomplete information will mean a delay in processing. Please ensure both parts are complete and accurate, and that all receipts are attached.

PART 1

Provincial Health Number: _____ Date of birth: (MM/DD/YYYY) _____

Please print & sign form before mailing/faxing.

_____ (MM/DD/YYYY) _____

Signature Date

PART 2

Prescription and / or medical expense details	Date expense incurred	Amount paid
	(MM/DD/YYYY)	
	(MM/DD/YYYY)	
	(MM/DD/YYYY)	
	(MM/DD/YYYY)	
	(MM/DD/YYYY)	
	(MM/DD/YYYY)	

Copies of original receipts may be submitted for reimbursement of medical or other additional expenses. Original receipts should be retained for 12 months from submission date, as they may be requested by the WCB for audit purposes.

When writing to the WCB, please print name and claim or firm number.

MISSION: ZERO