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 Saskatchewan Workers' Compensation Board (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: _____

Association you are registered/licensed with: _____

Qualifications: attach a copy of your current license, Authorized Practice Endorsement (APE), supervision agreement, if applicable, and proof of credentials. Visit the WCB website at wcbsask.com/mental-health-providers to learn more.

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notify the WCB if I cannot abide by future standards and requirements and my accreditation and billing number will be withdrawn.

_____ _____ (mm/dd/yyyy)

Signature of provider Date