WORKSAFE BC

Physician's Invoice

This invoice must be submitted within 90 days of the date of service. **Fax** or mail completed form to WorkSafeBC as indicated below. **All fields with * are required for payment to be processed.** Failure to provide this information may result in processing delays. Complete all other fields (if possible). Incomplete invoices may be returned for resubmission.

PAYMENT SERVICES
Phone 604.276.3085
Toll-free 1.888.422.2228

FAX
604.233.9777
Toll-free **1.888.922.8807**

MAIL
Payment Services, WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Payment information

		Invoice number	Invoice date* (yyyy-mm-dd)
Contract ID	Payee name	Payee number*	Facility number, if applicable
Referred by facility (facility number)	Referred by facility (name of facility)	Practitioner name	
Practitioner number (may be the same as payee number)	Referred by practitioner (practitioner number)	Referred by practitioner (name of practitioner)	
Mailing address for payment	City	Province	Postal code*
Telephone number (include area code)	Fax number (include area code)		

Service recipient information (worker or other person who received service)

Service recipient last name*	Service recipient first name*
Service recipient date of birth* (yyyy-mm-dd) - -	Service recipient personal health number* (CareCard number)
WorkSafeBC claim number (if available)	Gender* Male ☐ Female ☐

Injury information

Date of injury* (yyyy-mm-dd)	Diagnostic code* (ICD-9 code)	
Side of body* Left ☐ Right ☐ Bilateral ☐ Not applicable ☐	Body part code*	Nature of injury code*

Service information

Service location code*	Date of service* (yyyy-mm-dd)	Fee code*	Fee description*	Number of services* (number of units)	When applicable: After hours indicator (X)	When applicable: Time call started (hh:mm)	When applicable: Time call ended (hh:mm)	Line item amount* (fee)

Invoice total amount*

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

WORK SAFE BC (See reverse of form for submission criteria.)

Physician's Report

SELECT ONE ONLY: ☐ **Physician's First Report (F8)** (required if you suspect the worker may be disabled beyond the day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease, or mental disorder)

☐ **The worker's condition or treatment has changed (F11)** (required if the worker's condition or treatment has changed since last report or if the worker is ready for return to work)

Date of service (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)	WorkSafeBC claim number
Employer's name	Worker's last name	
Employer's telephone number (must include area code)	First name / Middle initial / Gender	
Operating location address	Mailing address (include postal code)	
Date of injury or when patient was first treated for this condition (yyyy-mm-dd)	Worker's contact telephone number (must include area code)	
Who rendered first treatment?	Worker's personal health number (BC Services Card/CareCard)	

8/11

Are you the worker's regular practitioner? ☐ YES ☐ NO

If YES, how long has the worker been your patient? ☐ 0–6 months ☐ 7–12 months ☐ > 1 year

Are there prior or other problems affecting injury, recovery, and disability?

From injury or last report, has the worker been disabled from work? ☐ YES ☐ NO If YES, as of what date? (yyyy-mm-dd)

Injury codes and descriptions

Diagnosis (text)		
CSA BP/AP (code)	CSA NOI (code)	ICD9 (code)

Clinical information

What happened? Subject Sx, examination, investigations, treatments/meds, specialists consult?

Return-to-work planning

Is the worker now medically capable of working full duties, full time? ☐ YES ☐ NO

If NO, what are the current physical and/or psychological restrictions?

Estimated time before the worker will be able to return to the workplace in any capacity

☐ Currently at work ☐ 1–6 days ☐ 7–13 days ☐ 14–20 days ☐ > 20 days

If appropriate, is the worker now ready for a rehabilitation program? ☐ YES ☐ NO If YES, select ☐ WCP or ☐ Other

Do you wish to consult with a WorkSafeBC physician or nurse advisor? ☐ YES ☐ NO

If possible, please estimate date of maximal medical recovery (full recovery or best possible recovery) (yyyy-mm-dd)

Payee number	Practitioner number
Payee name	Practitioner name

Additional information can be recorded on form 8/11 Addendum, Practitioner's Report/Additional Information

The *Workers Compensation Act* requires that the Physician's First Report, containing all the information requested, shall be furnished to WorkSafeBC (the Workers' Compensation Board) within **3 days** after the date of first attendance to the worker.

Practitioner — This report needs to be completed and submitted only when, in the case of a First Report (F8):

1. You suspect the worker may be disabled beyond the day of injury
2. If the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease, or mental disorder
3. If none of the above criteria apply and WorkSafeBC requests this report (bill fee item 19927)
4. If a First Report should have been sent by #1 and 2 being met but was not, send the report and bill a fee item 19900

In the case of a follow-up visit, submit only (F11):

1. If the worker's condition or treatment has changed since the last report or if the worker is ready for return to work
2. It is not necessary to answer the following questions if completing a report for a follow-up visit (F11)
   - Are you the worker's regular physician? If YES, how long has the worker been your patient?
   - Who rendered first treatment?

IN ALL OTHER CASES, ONLY YOUR PRACTITIONER ACCOUNT FOR PROCEDURES OR VISIT IS REQUIRED.

Completed Practitioner Reports (paper versions) should be sent by fax to:

Lower Mainland	Fax 604.233.9777
Toll-free	Fax 1.888.922.8807
or by mail to:	**WorkSafeBC** **PO Box 4700 Stn Terminal** **Vancouver BC V6B 1J1**

For claim/claimant inquiries, phone:

Call Centre	604.231.8888 or toll-free 1.888.967.5377

For invoice inquiries, phone Payment Services:

Lower Mainland	604.276.3085
Toll-free	1.888.422.2228

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Physician Office Use Only