WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

Mail to:
PO Box 94460 Stn Main
Richmond BC V6Y 2V6

RESET

WORKSAFEBC HEALTH CARE CLAIM

Payment Services

This form is to be used to request reimbursement for health care expenditures. Only expenses related to the compensable injury will be paid and only at the applicable WorkSafeBC rate. **Note: User fees are not reimbursable.**

Not all medical expenses are covered. If in doubt please check with your WorkSafeBC representative before incurring an expenditure. **Enclose all original receipts.** Keep a copy of the receipts for your records. WorkSafeBC does not return receipts.

For help completing this form, or for more information, please call us at 604 276-3085 or 1 888 422-2228.

THIS SECTION MUST BE COMPLETED IN FULL

Claimant's last name	Claimant's first name		Care card number	WorkSafeBC claim number
Claimant's address		Postal code	Has your address changed? Yes ❒ No ❒	Daytime phone number ( )
Company or employer name		Nature of injury or illness		

	Quantity and name of medication or supply	Date of purchase *(dd/mm/yyyy)*	Drug identification number (DIN)	Rx number	Indication for use *(example: pain killer, antibiotic, antidepressant etc.)*	Amount paid	Name of physician prescribing medication or supply
	EXAMPLE: 100 Ibuprofen 400 mg	**29/04/2006**	**506052**	**123456**	**Anti-inflammatory**	**$10.00**	**Dr. Wilson**
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

This section should be completed by pharmacy if billing WorkSafeBC direct.

Pharmacy name	Pharmacy vendor number	Reimburse Claimant ❒ Pharmacy ❒
Pharmacy address		

I certify that I incurred these expenses and that they relate to my compensable injury. All information is correct.

Signature	Date *(dd/mm/yyyy)*

DO NOT WRITE IN THIS SPACE
WORKSAFEBC USE ONLY

PLEASE ENCLOSE ALL **ORIGINAL** RECEIPTS WITH THIS FORM.