Payment Services
PO Box 94460 Stn Main
Richmond BC V6Y 2V6
Toll-free phone within BC 1 888 967-5377

Fax Attn: Payment Services
604 276-3195
Toll-free fax 1 888 922-3299

HEARING AID PROVISION AND SERVICES INVOICE

A. Payment information

	Billing date *yyyy-mm-dd*
Payee number *(for payment purposes)*	Date of service *(if different than billing date)*
Clinic name	Clinician name
Mailing address for payment	City / Province
Telephone number ( )	Fax number ( )

B. Worker information

Personal health number	WorkSafeBC (WCB) claim number	Date of birth *yyyy-mm-dd*
Worker's last name	First name	Gender Female ☐ Male ☐

C. Service details

Type of service	Fee item code	Description	Ear(s)	Cost per item	Total cost
Fitting fee *(requires verification measures)*	19680	Make, model, and serial number			
First-time fitting fee	19681		N/A		
In-house service fee	19687				
Out-of-office repair fee	19688				
Manufacturer's repair cost *(invoice incl. shipping)*	19698				
Ear impression	19691				
Ear mold cost *(invoice incl. shipping)*	19699				
Accessories	19693				
Photocopy *(must be legible)* *(circle applicable fee code(s))*	19689/ 19690		N/A		
Diagnostic fee *(circle applicable fee code(s))*	19696/ 19697		N/A		
Postage and insurance *(must live > 48 km round trip from nearest clinic)*	19700				
Other *(please specify fee item code)*					
				TOTAL COST	$

D. Cost share *(please read before signing)*

I agree that since I have a hearing aid that is more expensive than that approved by WorkSafeBC, I will be solely responsible for the additional cost of the aid(s) as well as for the cost and maintenance of a remote control if one is required for the aid(s).

Signature of WorkSafeBC client		Cost share number *(internal use only)*	Fee item code 19695
WorkSafeBC amount $	Client amount $	TOTAL $	

E. Service provider

Comments

I hereby certify that I have rendered the above goods and/or services to the client named above in accordance with all of the standards of the WorkSafeBC Hearing Aid Program.	Signature of clinician

F. Client *(please read before signing and see page 2 for further information)*

I hereby certify that I have an accepted WorkSafeBC claim for hearing loss and am in need of the goods and/or services provided.	Signature of WorkSafeBC client

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.