WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESIDENTIAL CARE SERVICES INVOICE

RESET

Please **FAX** 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.

Number of pages sent
_____ of _____

If additional invoicing space is required to list all items you wish to bill for, please submit a second invoice form (83D103).

HEALTH CARE SERVICES
Phone 604 232-7787
Toll-free 1 866 244-6404

FAX
604 276-3195
Toll-free **1 888 922-3299**

MAIL
WorkSafeBC
PO Box 94460 Stn Main
Richmond BC V6X 8V6

Invoice number*	Invoice date* *(yyyy-mm-dd)*
Contract ID*	Service location code

Payment information

Provider (agency/payee) name*		Payee number*
Mailing address for payment		
City	Province	Postal code*
Telephone number *(please include area code)*	Fax number *(please 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*	Date of injury *(yyyy-mm-dd)*

Service information

Date of service* *(yyyy-mm-dd)*	**Fee item code***	**Fee description***	*(A)* **Number of days*** *(number of units)*	*(B)* **Per diem amount*** *(cost per unit)*	*(A) x (B)* **Line item amount***	**Comments**
				Invoice total amount*		

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.