wcb Workers' Compensation Board – Alberta

PO BOX 2415
EDMONTON AB T5J 2S5
Fax **780-427-5863**

C012
OUTPATIENT HOSPITAL ACCOUNT

Hospital Name	
Number	
Employer's Name	
Employer's Address *Street*	
City/Town *Province* *Postal Code*	
Employer's Telephone Number	
Date of Accident *(Year / Month / Day)*	
Type of Injury *(burn, fracture, bruise, etc.)*	
Body Part *(hand, eye, back, etc., state left or right)*	
Name of Attending Physician	

WCB Claim Number	
Patient's *(Surname)* *(First Name)* *(Initial)*	
Address *Street*	
City/Town *Province* *Postal Code*	
Patient's Hospital Number	
Date of Birth *(Year / Month / Day)*	
Personal Health Number	
Occupation	

Physiotherapy (indicate dates of treatment) * for more than one month, use a second invoice

Yr	Mo	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Rate	Total $

Occupational Therapy (indicate dates of treatment) * for more than one month, use a second invoice

Yr	Mo	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Rate	Total $

Date of Service: *(Year / Month / Day)*	Description of Treatment and Supplies	Amount

WCB use Only		
Indexing Instructions:	Treatment and Supplies	$
	Therapy Amount Billed	$
Date of service *(Year / Month / Day)*	**Total Amount Billed**	$