wcb Workers' Compensation Board – Alberta
P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

C1282
Translation and Interpretation Services
Invoice Correction

WORKER DETAILS

			WCB Claim Number	Date of Accident *(yyyy/mm/dd)*
Surname	First Name and Initial			Date of Birth *(yyyy/mm/dd)*
Address Street	City/Town	Province	Postal Code	Telephone Number
Date Originally Submitted *(yyyy/mm/dd)*	Invoice Number			

Please submit only one Invoice Correction per Date of Service

CORRECTIONS ***(Must be submitted within 2 months of the date of services)***

	Fee Code	Description		Quantity	Unit Cost	Amount
Was:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Should be:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Was:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Should be:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Was:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Should be:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Was:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			
Should be:		☐ Not billed, or	Date of Service *(yyyy/mm/dd)*			

ADDITIONAL COMMENTS

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.
CORRECTIONS MUST BE SUBMITTED WITHIN 2 MONTHS OF BEING NOTIFIED BY WCB OF AN ERROR.

(Surname)	*(First Name)*	*(Initial)*	Claim Number

Name and Address to Whom Fee is Payable (print)	Signature:	
	Print Name:	
	Telephone Number:	Fax Number:
	Provider Reference Number:	Date *(yyyy/mm/dd):*
WCB Billing Number:		

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.