Workers' Compensation Board – Alberta
Box 2415
Edmonton, AB T5J 2S5
Fax: 780-427-5863 or 1-800-661-1993
contact.centre@wcb.ab.ca

C774
Pharmacy prescription invoice

WORKER DETAILS

			WCB claim number
Surname	First name and initial		Date of birth (dd/mm/yyyy
Address	City or town	Province	Postal code

Date dispensed (dd/mm/yyyy)	Quantity	Drug identification number (DIN)	Description	Prescribing doctor	Amount
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$

Note: Injured workers should not be provided a receipt for prescriptions directly billed to WCB. **Total amount:** $ 0.00

PROVIDER DETAILS

		Provider's invoice number
Name and address of pharmacy to whom fee is payable (please print):	Provider signature	
	Provider name (please print)	
	Phone number	Fax number
	Provider email address	Date submitted (dd/mm/yyyy)

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.
THIS FORM MUST HAVE A WCB CLAIM NUMBER.