Workers' Compensation Board
Alberta

Box 2415
Edmonton AB T5J 2S5
**Fax (780) 427-5863**
**1-800-661-1993**

# INPATIENT HOSPITAL ACCOUNT

| | |
|---|---|
| Hospital Name | WCB Claim Number |
| Number | Patient's *(Surname)* *(First Name)* *(Initial)* |
| Employer's Name | Address *Street* |
| Employer's Address *Street* | *City/Town* *Province* Postal Code |
| *City/Town* *Province* Postal Code | Patient's Hospital Number |
| Employer's Telephone Number ( ) | Date of Birth *(Year / Month /* |
| Date of Accident *(Year / Month / Day)* | Personal Health Number |
| Type of Injury *(burn, fracture, bruise, etc.)* | Occupation |
| Body Part *(hand, eye, back, etc., state left or right )* | |
| Name of Attending Physician | |

| | |
|---|---|
| Date of Admission *(Year / Month / Day)* | Date of Dishcharge *(Year / Month / Day)* |
| Billing for Period From *(Year / Month / Day)* | To *(Year / Month / Day)* |

Public Ward _____ Days at $ _____ $ _____

Semi-Private Ward _____ Days at $ _____ $ _____

Private Ward _____ Days at $ _____ $ _____

Sub Total $ _____

**WCB Use Only**

**Reason for preferred accommodation**

☐ Elective Admission ☐ Isolation

☐ Other (*Specify*) _____

Description of supplies provided on discharge

_____ $ _____

**Total Amount Billed** $ _____