wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

C552
CHIRO ADDITIONAL TREATMENT INVOICE

WORKER DETAILS

Surname	First Name and Initial	WCB Claim Number
		Date of Birth *(Year / Month / Day)*
Address Street	City/Town / Province	Postal Code

Invoice Items

Date of Service *(YYYY/MM/DD)*	Health Service Code	Description	Diagnostic Code	Fee Submitted
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total Amount Billed:	**$**

Sundry Items

Date of Service *(YYYY/MM/DD)*	Health Service Code	Description	Quantity	Fee Submitted
				$
				$
				$
			Total Amount Billed:	**$**

Name and address to whom fee is payable: (please print)	Signature:	Telephone Number
	Printed Name:	Fax Number
WCB Billing Number: _____	Date: *(Year / Month / Day)*	Provider's Reference Number:

This form MUST be accompanied by a Progress/Discharge Report and must have a WCB Claim Number

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