Workers' Compensation Board
Alberta

PO BOX 2415
Edmonton AB T5J 2S5
Fax **780-427-5863**
1-800-661-1993

M007B
ACUPUNCTURE INVOICE

Please print clearly or type

WCB Claim Number

Personal Health Number

Patient's *Surname* *First Name* *Initial* Date of Birth *(Year / Month / Day)*

Address *Street* *City/Town* *Province* *(Postal Code)*

Telephone Number | Date of Accident *(Year / Month / Day)* | **Part of Body** | Type of Injury

Date of Service *(Year / Month / Day)*	**Type of Service**	**Fee Submitted**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10,		
11.		
12.		
13.		
14.		
15.		
16.		

☐ Continued Treatment ☐ Final Treatment

Total Amount Billed

This document MUST be accompanied by a Progress or Discharge Report and must have a WCB Claim Number.

Name and address to whom fee is payable: *(please print)*

Telephone Number

Fax Number

Print Name:

WCB Billing Number. *(If applicable)*

Signature:

Date *(Year / Month / Day)*

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