



Payee Code _____
Claim No. _____
Medicare No. _____
Date of Accident _____

DOCTOR'S ACCOUNT

Required to be filled out and ITEMIZED IN FULL and sent to WorkSafeNB. The Act provides that application for payment be made in writing within three months after such medical aid has been completely rendered.

Name of Worker _____	Name of Employer _____
Address _____	Address _____

IMPORTANT: In order to process payment for this invoice, WorkSafeNB must have the **CONSULT/REPORT** for the services rendered (when applicable).

DATE	WHERE ATTENDED	SHOW: (1) Full description of services rendered at EACH attendance. AND (2) Diagnosis of injury (where Form 8 not completed).	SERVICE CODE	FEE	
Please use BASE FEE only. WorkSafeNB will apply any eligible bonuses automatically.				AMOUNT CHARGED	
TOTAL					

STAMP OR TYPE NAME & ADDRESS OF DOCTOR DATE _____	I DECLARE THAT THIS IS A CORRECT STATEMENT OF SERVICES RENDERED BY ME FOR WHICH I HAVE RECEIVED NO PAYMENT _____ Doctor's Signature
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