Doctor.....

MEDCOM BILLING SYSTEMS INC.
WCB CLAIM

For electronic billing of WCB claims, the following information is mandatory:
Surname..... First Name..... Sex.....
Birthdate(d/m/y).....
PHN..... Date of Service (d/m/y).....
WCB Claim # (if assigned)..... Date of Injury (d/m/y).....
Injury codes as per pages 6-12 of WCB Billing Guide: Side of Body (L,R,B or N)..... Body Part (5 digits).....
Nature of Injury (5 digits)..... Fee items..... ICD code..... Time (if required).....

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To avoid rejected claims, please ensure that the foregoing information matches exactly with Form 8 (fee item 19900) or Form 11 (fee item 19902). Forms must be faxed immediately to WCB. Forms will only be registered with WCB if they are entirely complete, accurate and legible. Please note your 'fax date' on all forms.

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