Prompt payment for Health Professionals and Providers

Our goal is to process your payment requests quickly and accurately. In order to avoid processing delays, **complete all fields** of either the Provider Payment Request form or the Provider Payment Request for Equipment/Supplies form and **write legibly**.

Incomplete or illegible payment requests will create processing delays.

Help on completing the forms
For help on completing the Provider Payment Request form or the Provider Payment Request for Equipment/Supplies form, refer to the instruction sheets that are attached to these forms.

Important: **Do not** use the Provider Payment Request form to bill for medical reports.

To bill for medical reports, please complete the billing section on the pre-printed WSIB report form, or place a payment label on the front page, bottom right hand corner of a narrative report.

Questions
If you have any questions about how to complete these forms, bill for services, equipment, or supplies, or if you require payment labels, please call our Health Professional Access Line at **416-344-4526** or **1-800-569-7919** between 8:30 a.m. and 4:30 p.m. Monday to Friday.

Electronic Billing
If you are interested in electronic billing (excluding medical reports), contact our external payment provider, **BCE Emergis** at **1-866-240-7492**.

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wsib ONTARIO

Mail to: 200 Front Street West Toronto ON M5V 3J1

or Fax to: 416-344-4684 OR 1-888-313-7373

Provider Payment Request

Important: *Do not use this form to bill for clinical reports.*

Please complete in full using black ink. *Start >*

Claim No.

Worker Information

Worker Surname	Given Name(s)	Initial	Worker's Impairment and/or ICD 9 Code (if available)
Address			Date of Incident (mm/dd/yy)
City	Prov.	Postal Code	Date of Birth (mm/dd/yy)

Provider/Facility Name and Full Address (city, province, postal code)

WSIB Reference No. (For WSIB use only)

START ADDRESS HERE >

Please complete the address above this line.

Important: Do not use this form to bill for medical reports.

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Provider Information:

WSIB Provider ID

HST Registration No.

Your Invoice No.

Treating Provider's Name (please print)

Telephone

Service/Treatment Information

Please use a separate line for each service code. Do not include previously billed services.

1.

Service Code	Description of Service/Treatment	Fee per Service	No. of Serv/Trt.	Amount Billed

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

2.

Service Code	Description of Service/Treatment	Fee per Service	No. of Serv/Trt.	Amount Billed

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

3.

Service Code	Description of Service/Treatment	Fee per Service	No. of Serv/Trt.	Amount Billed

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

4.

Service Code	Description of Service/Treatment	Fee per Service	No. of Serv/Trt.	Amount Billed

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Important: Do not use this form to bill for medical reports.

Total Billed ▶ **(1 + 2 + 3 + 4 = Total)**

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I hereby certify that the information being submitted is true, correct and complete.

Name (please print):	Signature: *Type your name and upload, or print and sign before returning to WSIB.*	Date (mm/dd/yy):

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For further information and/or inquiries, please see our website **www.wsib.on.ca** or call **1-800-387-0750.**

See instructions below

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Provider Payment Request Form

Important: Do not use the Provider Payment Request Form to bill for clinical reports.

INSTRUCTIONS

For prompt payment, complete as per the instructions given below.

WORKER INFORMATION

1. *Claim Number:* Enter worker's WSIB claim number. This is required to process the payment.
2 *Name:* Print Surname, Given Name(s) and Middle Initial.
3. *Worker's Impairment and/or ICD 9 Code:* Enter diagnosis or ICD 9 code for which treatment is being provided, if available.
4. *Date of Incident:* Enter reported date of incident.
5. *Address:* Enter current mailing address.
6. *Date of Birth:* Enter birth date.
7. *WSIB Reference No.:* Please do not complete. For WSIB use only.

PROVIDER INFORMATION

8. *Provider/Facility Name and Full Address:* Enter the name and full address of the provider/facility submitting the bill.
9. *WSIB Provider ID:* Enter the 9 digit WSIB assigned billing number. This is required for payment.
10. *HST Registration No:* Enter your HST registration number, if HST is being billed (using service code **ONHST**).
11. *Your Own Invoice No.:* Enter your own invoice number. (Your reference number for reconciliation purposes.)
12. *Treating Provider's Name:* Enter the name of the individual providing the service/treatment.
13. *Telephone Number:* Provide the telephone number of the individual completing the payment request form.

SERVICE/TREATMENT INFORMATION

14. *Service Code:* Enter appropriate service code. Refer to the WSIB Fee Schedule.
15. *Description of Service/Treatment:* Provide a brief description of service/treatment provided.
16. *Fee per Service:* Enter fee per service/treatment from the appropriate WSIB Fee Schedule.
17. *No. of Serv./Trt.:* Enter the number of services/treatments that you are billing.
18. *Amount Billed:* Enter the total amount for the one service code.
19. *Service Date:* Enter month and year. Select date(s) of service by (✓). Use a separate line for each month/service code.
20. *Total Billed:* Enter the total sum of all fees billed.
21. *Name:* Enter the name of the individual completing the form.
22. *Signature & Date:* Signature of individual completing the payment request form and date when completed.

For information on electronic billing, please contact Telus at 1-866-240-7492, via e-mail at provider.mgmt@telus.com or visit their website at telushealth.com.