July 2016

WorkplaceNL

MAIL FORM TO:
146-148 Forest Road P.O. Box 9000
St. John's NL A1A 3B8
FAX FORM TO:
f 709.738.1479
f 1.866.553.5119

CALL US AT:
t 709.778.1000
t 1.800.563.9000
VISIT US AT:
workplacenl.ca

WorkplaceNL Claim Number	**FORM 94**

HOSPITAL ACCOUNT

WORKER'S NAME			EMPLOYER	
ADDRESS			DATE OF INJURY YEAR MONTH DAY	PATIENT'S MCP NUMBER
CITY OR TOWN	POSTAL CODE	TELEPHONE NO.	ATTENDING PHYSICIAN	
NATURE OF INJURY				

IN-PATIENT SERVICES:

DATE ADMITTED YEAR MONTH DAY	ADMISSION NO.	DATE DISCHARGED YEAR MONTH DAY	NO. OF DAYS	RATE PER DAY	**TOTAL IN-PATIENT CHARGE**

OUT-PATIENT SERVICES:

DATE OF SERVICE YEAR MONTH DAY	DESCRIPTION	AMOUNT

I declare that the above particulars are correct and no payment has been received directly or indirectly for anything charged in this account except as noted.

NAME OF HOSPITAL

AUTHORIZED SIGNATURE

WorkplaceNL HOSPITAL NO.

DATE OF INVOICE YEAR MO DAY

FOR WorkplaceNL USE ONLY

APP. _____

DATE _____

TOTAL OUT-PATIENT CHARGE

PLEASE RETURN ORIGINAL TO WORKPLACENL AND RETAIN A COPY FOR YOUR RECORDS