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

Please indicate applicable number **WorkplaceNL Claim Number (Worker)**	**FORM 92**

Doctor's Account

MCP NUMBER	PART OF BODY
WORKER'S - SURNAME	GIVEN NAME(S)
WORKER'S MAILING ADDRESS	
TELEPHONE NUMBER	

(ENTER WHERE APPLICABLE)

DATE YY MM DD	TIME OF SERVICE	MCP FEE CODE	PRIMARY PROCEDURE ✓	CAPACITY	FEE CLAIMED (a)	TIME UNITS/ INTERVALS	TOTAL UNIT FEE (b)	SURGICAL PREMIUM CODE	SURGICAL PREMIUM FEE (c)	TOTAL CLAIMED (a + b + c)

If physician is a G/P, billing surgical assistant's services, please indicate method of billing.

☐ Standard ☐ Dedicated

If two surgeons are working together at the above procedure(s) please indicate if you are:

☐ Operating Surgeon ☐ Specialist Assist

If billing more than one procedure please indicate the primary procedure with a check mark in the column next to the MCP Fee Code.

☐ **REPORT FEE CLAIM** **If checked, provide dates**		
YY	MM	DD

I declare that the above is a correct statement of the services rendered by me and I have received no prior payment from WorkplaceNL.	WorkplaceNL Physician's Billing Number	Date of Invoice (YY MM DD) YY MM DD
Note: If you fax**, do not mail the original. Keep the original** for your files.	PHYSICIAN'S NAME _____ Physician's Signature _____	