Draft-Standard Invoice (CF-INV-1)

For accidents that occur on or after **January 1, 2027**

Rules for invoice → Health care service (as defined), and payable under a prescribed Care-First benefit or Program of Care.

- Guidance: An invoice may include only health care services, as defined, that are payable under a prescribed benefit, program of care, or authorized extension.

Part 1. Claimant Information

Last Name	First Name	Middle Name(s)

Mailing Address	City or Town

Province	Country	Postal Code	Email Address

Telephone Number	Date of Birth *(dd-mm-yyyy)*	Date of Accident *(dd-mm-yyyy)*

Policy Number (if known)	Claim Number (if known)

Insurance Company

Part 2. Health Care Practitioner Information

Full Name of Health Care Practitioner

Profession

Professional License Number

Mailing Address

City	Province	Country	Postal Code

Clinic Name	Administrative Contact's Full Name

Telephone Number	Fax Number

Email	Preferred Contact Method
	☐ Phone ☐ Email

Direct Billing / Registry Number (if applicable)

Part 3. Program of Care Billing (Bundled Services)

Complete only when billing under a prescribed Program of Care.

Program Component	Code	Quantity	Total	Notes
Initial assessment		Fixed		
Treatment block 1				
Midpoint				
Treatment block 2				
Concluding report				

Note: Services delivered under a Program of Care should be billed in accordance with the prescribed Program of Care structure and fee arrangements. **See guide/fee schedule.**

Part 4. Fee-for-Service Items (Outside Program of Care)

Used for non-protocol care, extended care, or disciplines outside a Program of Care.

Service Description	Code	Duration/Units	Fee	Total
Notes				

Add service

Part 5. Reports & Documentation (Billable Reports)

Report Type	Code	Date Submitted	Fee	Total

Add report

Part 6. Equipment, Supplies & Assistive Devices

Item	Code	Quantity	Unit Cost	Total
Prescription / Justification Attached? ☐ Yes ☐ No				

Add item

Part 7. Third-Party Services (If Applicable)

Service Vendor	Fee	Total

Prescription / Justification Attached?

☐ Yes ☐ No

Notes

Add report

Part 8. Total Invoice Summary

Program of Care Total	
Fee-for-Service Total	
Reports Total	
Equipment / Supplies Total	
Travel Total	
Other	
Prior amount billed	
Grand Total	

Part 10. Health Care Practitioner Signature

I certify that:

- the services invoiced were provided as claimed;
- the services are clinically appropriate and within my scope of practice;
- no duplicate billing has been submitted to any other payer; and
- records supporting this invoice will be retained for audit.

Full Name of Health Care Practitioner (Please Print) | Date *(dd-mm-yyyy)* | Signature

Part 11. Insurer Use Only

Invoice Received Date *(dd-mm-yyyy)*	Approved Amount
▼ ▼ ▼	

Adjustments / Reasons

Reviewer Name / ID	Payment Date *(dd-mm-yyyy)*
	▼ ▼ ▼