



Purpose

The Health Care Provider Invoicing and Reporting (HCPIR) application is available to support Occupational Therapy practitioners. The HCPIR application is designed to streamline the invoice and report submission process.

This job aid is a step-by-step guide to submit a report, submit an invoice, and request a treatment extension or submit a discharge notification in the new HCPIR web application.



Overview

Topics Covered

[Enter Service Provider Information & Customer Details](#)

[Submit an Initial Report](#)

[Submit a Reassessment Report](#)

[Submit a Final Report](#)

[Submit Clinical Records](#)

[Invoice for Patient Care](#)

[Submit a Request for a Treatment Extension](#)

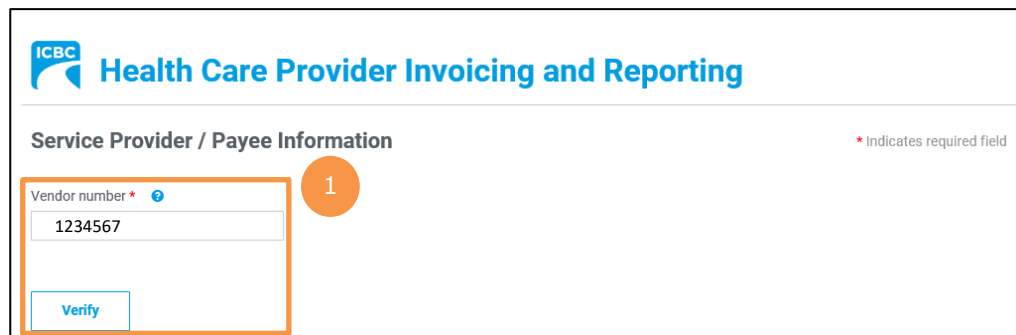
[Submit a Discharge Notification](#)



Service Provider Information & Customer Details


Enter Service Provider Information

1. To begin your submission, enter your vendor number and click the **Verify** button.
2. Validate the auto-populated information (for example, *Business name and Business address*).
 - a. If the auto-populated information is incorrect, click the **Help** icon next to the field to learn how to update vendor information.
3. Enter a valid email address in the *Email address* field. If you request a final copy of the submission, it will be sent to the email address that you have entered.

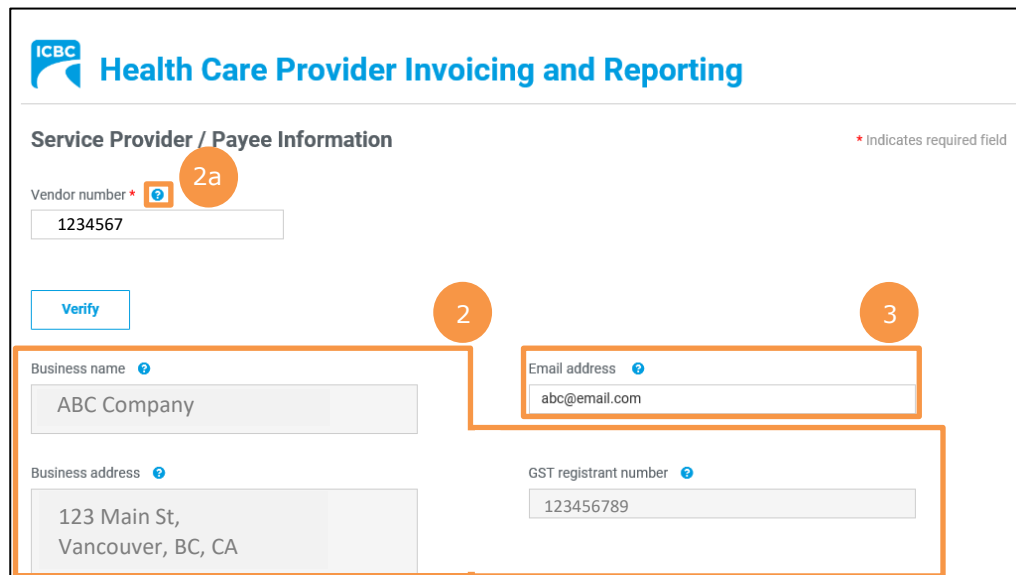


ICBC Health Care Provider Invoicing and Reporting

Service Provider / Payee Information * Indicates required field


Vendor number *  1234567 1

[Verify](#)





ICBC Health Care Provider Invoicing and Reporting


Service Provider / Payee Information * Indicates required field


Vendor number *  1234567 2a

[Verify](#)

Business name  ABC Company 2

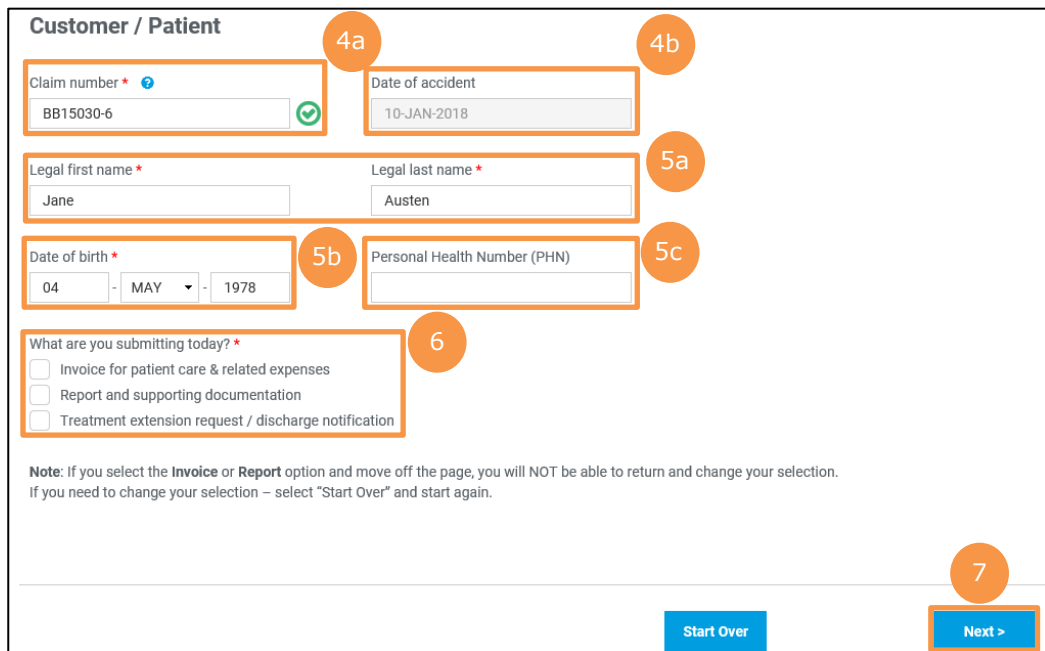
Business address  123 Main St,
Vancouver, BC, CA

Email address  abc@email.com 3



GST registrant number  123456789

Enter Customer Details

4. Scroll down to the *Customer / Patient* section and enter the required customer details.
 - a. Enter the claim number. Remember that each submission can only be made for one customer on one claim number.
 - b. The *Date of accident* will auto-populate.
5. Enter the customer details.
 - a. Enter the customer's legal first name and legal last name. If a name other than the customer's legal name is used (for example, a nickname), this could cause delays in processing the submission and receiving payment.
 - b. Enter the customer's date of birth.
 - c. Enter the customer's personal health number. This is optional, however, it will assist pairing the submission to the correct customer in ICBC's claim system and ensure that the submission is reviewed by the appropriate ICBC representative.
6. Select the appropriate option in the *What are you submitting today?* field below.
 - a. "Invoice for patient care & related expenses"
 - b. "Report and supporting documentation"
 - c. "Treatment extension request / discharge notification"
7. Click the **Next** button.



Customer / Patient

4a Claim number * 
BB15030-6 

4b Date of accident
10-JAN-2018

5a Legal first name * Jane Legal last name * Austen

5b Date of birth * 04 - MAY - 1978

5c Personal Health Number (PHN)

6 What are you submitting today? *

☐ Invoice for patient care & related expenses

☐ Report and supporting documentation

☐ Treatment extension request / discharge notification

Note: If you select the **Invoice** or **Report** option and move off the page, you will NOT be able to return and change your selection. If you need to change your selection – select "Start Over" and start again.

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[Start Over](#) [Next >](#)



Tip: If you select "Report and supporting documentation," then "Invoice for patient care & related expenses" will be automatically selected.




Tip: If you select the "Invoice" or "Report" option and proceed to the next page, you will not be able to return and change your selection. To change your selection, click the **Start Over** button and start again.



Initial Report

Enter Details of the Initial Report

1. In the *Medical Report* section, enter the required details of the report you are submitting.
 - a. Enter the date of the report being submitted in the *Date of report* field.
 - b. Select "Occupational Therapy" from the drop-down menu in the *Who is submitting?* field.
 - c. Select "Initial Report" from the drop-down menu in the *Which report are you submitting?* field.
 - d. Enter the practitioner number. This is optional.
 - e. Enter the practitioner first name and last name.
2. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen

Claim number: BB15030-6

Date of accident: 10-JAN-2018

Submission date: 21-JUL-2019

Medical Report

Step 1/3

* Indicates required field

1a

Date of report *

01-JUL-2019

1b

Who is submitting? *

Occupational Therapy

1c

Which report are you submitting? *

Initial Report

1d

Practitioner number

Practitioner first name *

Sam

Practitioner last name *

Brown


1e

2

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Next >

3. Enter details of the report you are submitting in the below *Medical Report* section.
 - a. Enter the date in which the customer was assessed by the medical practitioner in the *Date of assessment* field.
 - b. To add another assessment date, click the **Add another date** button. You can add up to four assessment dates.
 - c. To remove an assessment date, click the **Trash** icon beside the session field.
 - d. Select whether the customer is currently off work in the *Is the patient currently off work?* field.
4. In the *Select One* field, select whether the customer's information is being shared with the customer's consent or because of a request from ICBC.
5. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 2/3

* Indicates required field

3a

Date of assessment *

01-JUL-2019

3b

Add another date

3d

Is the patient currently off work? *

☒ Yes ☐ No

4

Select one: *

☒ I have obtained consent from the patient/client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

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- In the final *Medical Report* section, click the **Browse** button to select the copy of the PDF report from your system to upload.



Tip: Blank copies of the PDF reports can be downloaded from the Business Partners web page, filled out and uploaded to the *Medical Report* screen.

- Click the **Attach** button to upload the file.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen
Claim number: BB15030-6
Date of accident: 10-JAN-2018
Submission date: 21-JUL-2019

Medical Report

Step 3/3

* Indicates required field

Attachments

Select the document you want to attach to this medical report and click Attach. *

Acceptable file types for attachment:
Documents (MS Excel, MS Word, Text, Msg/Eml, PDF)
Images (Jpeg, Png)


File
6
7
Browse...
Attach

25MB remaining / 25MB limit

File name	Size (MB)	Document title
No file attachments to show...		

Preview
< Previous
Next >

8. To remove an incorrect file, click the **Trash** icon to delete the uploaded file.
9. To preview the uploaded document, click the **Preview** button.
10. Click the **Next** button to proceed to the *Invoicing* screen. Based on your submission, select fields in the *Invoice* screen will auto-populate. Refer to the [Invoice for Patient Care](#) section of this job aid for more information.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 3/3

24.99MB remaining / 25MB limit

File name	Size (MB)	Document title
Initial Visit Report.docx	0.01	OT - Initial

8

9

10

Preview

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Next >

Practitioner / Therapist 1

Treatment / Service type * Practitioner number Practitioner first name * Practitioner last name *

Occupational Therapy Sam Brown

Report

Date of report * Report type * Hours * Minutes * Fee *

01-JUL-2019 Initial Report \$

Related expense for report

Currently no related expense added


Add related expense



Reassessment Report

Enter Details of the Reassessment Report

1. In the *Medical Report* section, enter the required details of the report you are submitting.
 - a. Enter the date of the report being submitted in the *Date of report* field.
 - b. Select "Occupational Therapy" from the drop-down menu in the *Who is submitting?* field.
 - c. Select "Reassessment Report" from the drop-down menu in the *Which Report are you submitting?* field.
 - d. Enter the practitioner number. This is optional.
 - e. Enter the practitioner first name and last name.
2. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 1/3 * Indicates required field

Date of report *

01-JUL-2019

Who is submitting? *

Occupational Therapy

Which report are you submitting? *

Reassessment Report

Practitioner number

Practitioner first name *

Practitioner last name *


Sam

Brown

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Next >

3. Enter details of the report you are submitting in the below *Medical Report* section.
 - a. Enter the date in which the customer was assessed by the medical practitioner in the *Date of assessment* field.
 - b. To add another assessment date, click the **Add another date** button. You can add up to four assessment dates.
 - c. To remove an assessment date, click the **Trash** icon beside the session field.
 - d. Select whether the customer is currently off work in the *Is the patient currently off work?* field.
4. In the *Select One* field, select whether or not the customer's information is being shared with the customer's consent or because of a request from ICBC.
5. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 2/3

* Indicates required field

Date of assessment *

01-JUL-2019

3a

Add another date

3b

Is the patient currently off work? *

☒ Yes
 ☐ No

3d

4

Select one: *

☒ I have obtained consent from the patient/client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

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- In the final *Medical Report* section, click the **Browse** button to select a file from your system to upload.



Tip: Blank copies of the PDF reports can be downloaded from the Business Partners web page, filled out and uploaded to the *Medical Report* screen.

- Click the **Attach** button to upload the file.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen

Claim number: BB15030-6

Date of accident: 10-JAN-2018

Submission date: 21-JUL-2019

Medical Report

Step 3/3

* Indicates required field

Attachments

Select the document you want to attach to this medical report and click Attach. *

Acceptable file types for attachment:
Documents (MS Excel, MS Word, Text, Msg/Eml, PDF)
Images (Jpeg, Png)

File

Browse...

Attach

25MB remaining / 25MB limit


File name	Size (MB)	Document title
No file attachments to show...		

Preview

< Previous

Next >

8. To remove an incorrect file, click the **Trash** icon to delete the uploaded file.
9. To preview the uploaded document, click the **Preview** button.
10. Click the **Next** button to proceed to the *Invoicing* screen. Based on your submission, select fields in the *Invoice* screen will auto-populate. Refer to the [Invoice for Patient Care](#) section of this job aid for more information.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 3/3

* Indicates required field

24.99MB remaining / 25MB limit

File name	Size (MB)	Document title
Reassessment Report.docx	0.01	OT - Reassessment

8

9

10

Preview

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Next >

Practitioner / Therapist 1

Treatment / Service type *

Practitioner number

Practitioner first name *

Practitioner last name *

Occupational Therapy

Sam

Brown

Report

Date of report *

Report type *

Hours *

Minutes *

Fee *

01-JUL-2019

Reassessment Report

\$

Related expense for report

Currently no related expense added


Add related expense



Final Report

Enter Details of the Final Report

1. In the *Medical Report* section, enter the required details of the report you are submitting.
 - a. Enter the date of the report being submitted in the *Date of report* field.
 - b. Select "Occupational Therapy" from the drop-down menu in the *Who is submitting?* field.
 - c. Select "Final Report" from the drop-down menu in the *Which Report are you submitting?* field.
 - d. Enter the practitioner number. This is optional.
 - e. Enter the practitioner first name and last name.
2. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen

Claim number: BB15030-6

Date of accident: 10-JAN-2018

Submission date: 21-JUL-2019

Medical Report

Step 1/3

* Indicates required field

1a

Date of report *

01-JUL-2019

1b

Who is submitting? *

Occupational Therapy

1c

Which report are you submitting? *

Final Report

1d

Practitioner number

1e

Practitioner first name *

Sam

Practitioner last name *


Brown

2

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Next >

3. Enter details of the report you are submitting in the below *Medical Report* section.
 - a. Enter the date in which the customer was assessed by the medical practitioner in the *Date of assessment* field.
 - b. To add another assessment date, click the **Add another date** button. You can add up to four assessment dates.
 - c. To remove an assessment date, click the **Trash** icon beside the session field.
 - d. Select whether the customer is currently off work in the *Is the patient currently off work?* field.
4. In the *Select One* field, select whether the customer's information is being shared with the customer's consent or because of a request from ICBC.
5. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 2/3

* Indicates required field

3a

Date of assessment *

01-JUL-2019

3b

Add another date

3d

Is the patient currently off work? *

☒ Yes ☐ No

4

Select one: *

☒ I have obtained consent from the patient/client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

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Next >

- In the final *Medical Report* section, click the **Browse** button to select a file from your system to upload.



Tip: Blank copies of the PDF reports can be downloaded from the Business Partners web page, filled out and uploaded to the *Medical Report* screen.

- Click the **Attach** button to upload the file.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen

Claim number: BB15030-6

Date of accident: 10-JAN-2018

Submission date: 21-JUL-2019

Medical Report

Step 3/3

* Indicates required field

Attachments

Select the document you want to attach to this medical report and click Attach. *

Acceptable file types for attachment:
Documents (MS Excel, MS Word, Text, Msg/Eml, PDF)
Images (Jpeg, Png)

File

Browse...

Attach

25MB remaining / 25MB limit


File name	Size (MB)	Document title
No file attachments to show...		

Preview

< Previous

Next >

8. To remove an incorrect file, click the **Trash** icon to delete the uploaded file.
9. To preview the uploaded document, click the **Preview** button.
10. Click the **Next** button to proceed to the *Invoicing* screen. Based on your submission, select fields in the *Invoice* screen will auto-populate. Refer to the [Invoice for Patient Care](#) section of this job aid for more information.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report


Step 3/3

* Indicates required field

23.16MB remaining / 25MB limit

File name	Size (MB)	Document title
Final.docx	1.84	OT - Final

8



9

10

Preview

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Next >

Practitioner / Therapist 1

10

Treatment / Service type * Practitioner number Practitioner first name * Practitioner last name *

Occupational Therapy Sam Brown

Report

Date of report * Report type * Hours * Minutes * Fee *

01-JUL-2019 Final Report \$

Related expense for report

Currently no related expense added


Add related expense



Clinical Records

Enter Details of the Clinical Records

1. In the *Medical Report* section, enter the required details of the report you are submitting.
 - a. Enter the date of the report being submitted in the *Date of report* field.
 - b. Select "Occupational Therapy" from the drop-down menu in the *Who is submitting?* field.
 - c. Select "Clinical Records" from the drop-down menu in the *Which Report are you submitting?* field.
 - d. Enter the date range of the customer's clinical records in the *Clinical records from* and *Clinical records to* fields.
 - e. Enter the practitioner number. This is optional.
 - f. Enter the practitioner first name and last name.
2. Click the **Next** button to continue.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Submission date: 21-JUL-2019

Medical Report

Step 1/2

* Indicates required field

1a

Date of report *

01-JUL-2019

1b

Who is submitting? *

Occupational Therapy

1c

Which report are you submitting? *

Clinical Records

1d

Clinical records from *

01-JUL-2019

Clinical records to *

18-JUL-2019

1e

Practitioner number

1f

Practitioner first name *

Sam

Practitioner last name *


Brown

2

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Next >

3. In the final *Medical Report* section, click the **Browse** button to select a file from your system to upload.
4. Click the **Attach** button to upload the file.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen

Claim number: BB15030-6

Date of accident: 10-JAN-2018

Submission date: 21-JUL-2019

Medical Report

Step 2/2

* Indicates required field

Attachments

Select the document you want to attach to this medical report and click Attach. *

Acceptable file types for attachment:
Documents (MS Excel, MS Word, Text, Msg/Eml, PDF)
Images (Jpeg, Png)

File

Browse...

Attach

25MB remaining / 25MB limit


File name	Size (MB)	Document title
No file attachments to show...		

Preview

< Previous

Next >

- To remove an incorrect file, click the **Trash** icon to delete the uploaded file.
- To preview the uploaded document, click the **Preview** button.
- Click the **Next** button to proceed to the *Invoicing* screen. Based on your submission, select fields in the *Invoice* screen will auto-populate. Refer to the [Invoice for Patient Care](#) section of this job aid for more information.



Health Care Provider Invoicing and Reporting


Customer: Jane Austen
Claim number: BB15030-6
Date of accident: 10-JAN-2018
Submission date: 21-JUL-2019

Medical Report

Step 2/2

* Indicates required field

24.99MB remaining / 25MB limit

File name	Size (MB)	Document title	
Clinical Records.docx	0.01	OT - [01JUL2019-18JUL2019]	<div>5</div> 

6

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Preview

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Practitioner / Therapist 1

Treatment / Service type *
Practitioner number
Practitioner first name *
Practitioner last name *

Occupational Therapy
Sam
Brown

Report

Date of submission *
Report type *
Hours *
Minutes *
Fee *

21-JUL-2019
Clinical Records
\$

Related expense for report

Currently no related expense added

Add related expense



Invoice for Patient Care

Enter Details of the Invoice

1. Validate the details of the service that the customer received.
 - a. Enter the invoice number in the *Your invoice number* field. This number will be printed on the PDF copy of your final submission and on the vendor statement when you receive payment from ICBC.
 - b. If a report is part of your submission, the *Treatment / Service type*, *Practitioner number* (this is optional), *Practitioner first name*, and *Practitioner last name* fields will pre-populate. Validate the pre-populated fields.
 - c. Validate the date of submission.
 - d. Validate the report type (for example, "Clinical Records").
2. The *fee* field will auto-populate based on the time entered.
 - a. Enter the length of time in the *hours* and *minutes* fields.
 - b. Based on the length of time entered, a dollar value in the *Fee* field will auto-populate.

Your invoice number * 1a

Practitioner / Therapist 1 1b

Treatment / Service type *	Practitioner number	Practitioner first name *	Practitioner last name *
Occupational Therapy		Sam	Brown

Report

Date of submission * 1c

Report type * 1d

Hours * 2a

Minutes * 2b

Fee * 2b

Related expense for report

Currently no related expense added

[Add related expense](#)

[Add session](#)

Add Related Expense

3. For any additional pre-approved expense related to the session click the **Add Related Expense** button to add the details in the *Related expenses for session* section.
 - a. Select the expense type from the dropdown menu in the *Expense type* field.
 - b. Enter the dollar value of the expense in the *Fee* field. If, for example, travel time was expensed, the amount of time would be entered in the *No. of hours* field in decimal hours and a fee amount would generate.
 - c. Provide additional information related to the expense type in the *Comment* field. This field can be used to describe what that expense is.
4. To add more than one related expense for a session, click on the **Add Related Expense** button.
 - a. Enter the details related to the additional expense.
5. To delete a related expense, click the **Trash** icon next to the expense you wish to delete.

Report

Date of submission *

Report type *

Hours *

Minutes *

Fee *

26-JUL-2019

Clinical Records

2

30

\$ 280.00

Related expense for report

Currently no related expense added

Add related expense

Session 1

Date of service *

Session type *

Hours *

Minutes *

Fee *

08-JUL-2019

Assessment/Treatment

1

30

\$ 168.00

Related expense for session

Expense type *

Comment ?

Fee *

Supplies and Equipment

\$ 20.00

3a

3c

3b

5

3

Add related expense



Tip: You can add a related expense for a medical report, a clinical record, or a treatment.

Add a Session

6. In the *Invoice* section, if the customer has multiple sessions with the same practitioner, click the **Add Session** button to add a session with the same practitioner.

a. Enter the details related to the additional session.

7. To delete a session, click the **Trash** icon next to the session.

Session 2

Date of service *

15-JUL-2019

Session type *

Assessment/Treatment

Hours *

1

Minutes *

30

Fee *

\$ 168.00

Trash icon

Add related expense

Add session

Add new practitioner / therapist

Related expense for session

Currently no related expense added

Add New Practitioner

8. In the *Invoice* section, if the customer has session with an additional practitioner or for a different treatment or service type, click the **Add new practitioner / therapist** button to add a session with a new practitioner.

a. Enter the details related to the session with the additional practitioner.

9. To delete a practitioner, click the **Trash** icon next to the session with the practitioner.


Practitioner / Therapist 2
8a

Treatment / Service type *
Practitioner number
Practitioner first name *
Practitioner last name *

Occupational Therapy

John

Ackerman

9


Session 1

Date of service *
Session type *
Hours *
Minutes *
Fee *

10-JUL-2019

Assessment/Treatment

1

30

\$ 168.00

Related expense for session

Currently no related expense added

Add related expense

8

Add session

Add new practitioner / therapist



Tip: A vendor that offers multiple services (for example, physiotherapy and massage therapy) can bill those services under one submission as long as the services are for the same customer under the same claim.



Tip: To bill for a type of therapy that is missing from your drop down list, visit the ICBC Business Partners page to learn how to request to have additional therapy types added to your vendor number.

Attach / Remove documents

10. Where applicable, attach documents supporting the related expenses.

a. Click the **Attach / Remove Documents** button to attach supporting documents.

Attachment(s) 25MB remaining / 25MB limit

File name	Size (MB)	Document title
No file attachments to show...		

0 records

10a

Attach / Remove documents

b. In the new screen displayed, select the treatment type and related expense type.

c. Click the **Browse** button to select the document that you wish to upload.

d. Click the **Attach** button once you have selected the required document.

11. To remove an incorrect document, select the checkbox next to the attached document and click the **Delete selected** button.

12. To return to the previous screen, click the **Save and return to invoice** button.

Invoice * Indicates required field

Attachments

Select a treatment and related expense type for the documents you want to attach, select files and then click Attach.
Acceptable file types for attachment: Documents (MS Excel, MS Word, Text, Msg/Eml, PDF) Images (Jpeg, Png)

Treatment type * Related expense type * **10b**

File

Browse... **10c** **Attach** **10d**

24.99MB remaining / 25MB limit

<input type="checkbox"/>	File name	Size (MB)	Document title
<input checked="" type="checkbox"/>	Supplies and Equipment Invoice.docx	0.01	OT - Supplies and Equipment

1 record

Delete selected **11**

24.99MB remaining / 25MB limit

12

Save and return to Invoice

13. In the Legal disclaimer section, review the disclaimer and select the checkbox to acknowledge it.

Attachment(s)
24.99MB remaining / 25MB limit

File name	Size (MB)	Document title
Supplies and Equipment Invoice.docx	0.01	OT - Supplies and Equipment

1 record

[Attach / Remove documents](#)

Subtotal
\$ 722.00

PST
\$ 0.00

GST/HST
\$ 11.20

Total
\$ 733.20

Legal disclaimer: *

☒ By submitting this invoice, the vendor certifies that the goods and/or services contained herein were provided to the customer for medical purposes by qualified and accredited persons. The vendor further certifies that the customer has received all goods and/or services as described and that the information provided for this claim payment is true and complete. It is understood and agreed that providing false or misleading information may result in the cancelation of the vendor's vendor number and ICBC may seek to recover damages and/or financial restitution.

Preview the Invoice Submission

14. If you wish, you can preview the PDF format of the invoice submission, click the **Preview** button.

GST/HST
\$ 11.20

Total
\$ 733.20

Legal disclaimer: *


☒ By submitting this invoice, the vendor certifies that the goods and/or services contained herein were provided to the customer for medical purposes by qualified and accredited persons. The vendor further certifies that the customer has received all goods and/or services as described and that the information provided for this claim payment is true and complete. It is understood and agreed that providing false or misleading information may result in the cancelation of the vendor's vendor number and ICBC may seek to recover damages and/or financial restitution.

[Preview](#)

[< Previous](#) [Submit](#)

15. To make a change to the invoice submission, click the **Previous** button to return to the section of the submission you wish to modify.

- To submit on the *Preview* section, click the Submit **button**
- To submit on the *Invoice* section, click the **Previous** button to exit from the *Preview* section, and click the **Submit** button on the *Invoice* section.



Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 10-JAN-2018 Service date: 21-JUL-2018

15b

15

15a

Print

< Previous

Submit

This is a preview of the invoice you will be submitting. Please review it and click "Previous" if you would like to make any changes or "Submit" to process your invoice.

GST/HST

\$ 11.20

Total

\$ 733.20

Legal disclaimer: *

☒ By submitting this invoice, the vendor certifies that the goods and/or services contained herein were provided to the customer for medical purposes by qualified and accredited persons. The vendor further certifies that the customer has received all goods and/or services as described and that the information provided for this claim payment is true and complete. It is understood and agreed that providing false or misleading information may result in the cancellation of the vendor's vendor number and ICBC may seek to recover damages and/or financial restitution.

15b

Preview

< Previous

Submit

16. Save the unique reference number generated for the submission. This number is printed on the PDF version of the submission and on the vendor statement.



Health Care Provider Invoicing and Reporting

Thank you for your submission.

16

Your reference number for this submission is 19-00001387.

Please record this number as it will be required for future communications regarding your submission.

If you wish to receive a PDF copy of your submission, click "Request PDF Copy". An email containing the PDF will be sent within 24 hours to the email address you provided during your submission.

[Request PDF Copy](#)

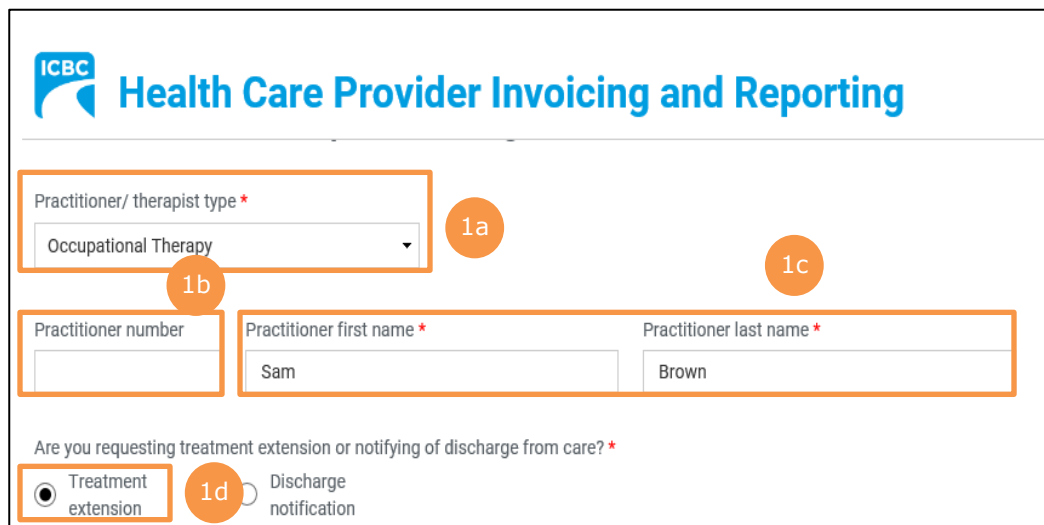
[Make another submission](#)



Submit a Request for a Treatment Extension

Enter Details of the Request for a Treatment Extension

1. In the *Treatment Extension Request / Discharge Notification* section, enter details of the extension request.
 - a. Enter "Occupational Therapy" in the *Practitioner / therapist type* field.
 - b. Enter the practitioner number. This is optional.
 - c. Enter the practitioner's first name and last name.
 - d. Select "Treatment extension" in the *Are you requesting treatment extension or notifying of discharge from care?* field.



ICBC Health Care Provider Invoicing and Reporting

Practitioner/ therapist type *
Occupational Therapy (1a)

Practitioner number (1b)


Practitioner first name *
Sam

Practitioner last name *
Brown (1c)

Are you requesting treatment extension or notifying of discharge from care? *

☒ Treatment extension (1d) ☐ Discharge notification

- e. Enter the number of additional sessions you will provide the customer in the *Number of additional sessions* field.
- f. Enter the anticipated discharge date.
- g. Enter the reason for treatment extension
Brief clinical rationale items to include in your extension request are
 - What are the functional/symptom improvements to date?
 - What are the current barriers to recovery?
 - What are the current functional limitations?
 - Does your treatment plan address these barriers? If so, how?



Health Care Provider Invoicing and Reporting

In order to consider your treatment extension, please provide the following information

1e
Number of additional sessions *

1f
Anticipated discharge date *

1g
Reason for treatment extension *

1. Functional/symptom improvement to date?
2. What are the current barriers to recovery?
3. What are the current functional limitations?
4. Does your treatment plan address these barriers? If so, how?

202 / 750 character limit

Enter Your Contact Details

2. Enter your contact details to ensure that the appropriate ICBC representative is able to contact you while processing the submission.
 - a. Select how you wish the appropriate ICBC representative to contact you in the *Contact preference* field. You are not required to provide both a phone and an email address. You may choose to provide one.

Reason for treatment extension *

Patient not showing satisfactory improvement.

45 / 750 character limit

2a
Contact preference *

☒ By phone
☒ By email

Contact phone number *
Contact email *

* Indicates required field

Preview

< Previous
Submit

Preview the Request for a Treatment Extension Submission

- To preview the PDF format of the request for a treatment extension submission, click the **Preview** button.

In order to consider your treatment extension, please provide the following information

Number of additional sessions * Anticipated discharge date *

Reason for treatment extension *

1. Functional/symptom improvement to date?
2. What are the current barriers to recovery?
3. What are the current functional limitations?
4. Does your treatment plan address these barriers? If so, how?

201 / 750 character limit

Contact preference *

☒ By phone ☒ By email

Contact phone number * Contact email *

3

Preview

< Previous Submit

- To make a change to the submission, click the **Previous** button to return to the section of the submission you wish to modify.
- Click the **Submit** button to submit the request for a treatment extension submission.
 - To submit on the *Preview* section, click the **Submit** button.
 - To submit on the *Treatment Extension Request / Discharge Notification* section, click the **Previous** button to exit from the *Preview* section, and click the **Submit** button on the *Treatment Extension Request / Discharge Notification* section.

ICBC Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 22-NOV-2017 Submission date: 21-FEB-2020

4 5a

Print < Previous Submit



ICBC

Health Care Provider Invoicing and Reporting

Customer: Jane Austern

Claim number: BB15030-6

Date of accident: 22-NOV-2017

Submission date: 26-FEB-2019

Treatment Extension Request / Discharge Notification

Practitioner/ therapist type *

Occupational Therapy

Practitioner number

Practitioner first name *

Sam

Practitioner last name *

Brown

Are you requesting treatment extension or notifying of discharge from care? *

☒ Treatment extension

☐ Discharge notification

In order to consider your treatment extension, please provide the following information

Number of additional sessions *

5

Anticipated discharge date *

30-MAR-2019

Reason for treatment extension *

Customer not showing satisfactory improvement

45 / 750 character limit

Contact preference *

☒ By phone

☒ By email

Contact phone number *

1-123-456-7890

Contact email *

abc@email.com

* Indicates required field

5b

Preview

< Previous

Submit

6. Save the unique reference number generated for the submission. This number is printed on the PDF version of the submission and on the vendor statement.



Health Care Provider Invoicing and Reporting

Thank you for your submission.

6

Your reference number for this submission is 19-00001387
Please record this number as it will be required for future communications regarding your submission.

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Submit a Discharge Notification

Enter Details of the Discharge Notification

1. In the *Treatment Extension Request / Discharge Notification* section, enter details of the discharge notification.
 - a. Enter "Occupational Therapy" in the *Practitioner / therapist type* field.
 - b. Enter the practitioner number. This is optional.
 - c. Enter the practitioner's first name and last name.
 - d. Select "Discharge notification" in the *Are you requesting treatment extension or notifying of discharge from care?* field.


Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 22-NOV-2017 Submission date: 21-FEB-2019

Treatment Extension Request / Discharge Notification

Practitioner/ therapist type *
 Occupational Therapy

Practitioner number
 [Empty field]

Practitioner first name *
 Sam

Practitioner last name *
 Brown

Are you requesting treatment extension or notifying of discharge from care? *
☐ Treatment extension
☒ Discharge notification

- e. Enter the discharge date.
- f. Select the reason that the customer is being discharged in the *Is the customer being discharged due to* field. If "Other" is selected, an explanation for why the customer is being discharged is required in the *Comment* field.


Discharge date *
 22-FEB-2019

Is the customer/ patient being discharged due to *
 Met treatment goal

Comment
 Met treatment goal
18 / 750 character limit

Preview the Request for a Discharge Notification

2. To preview the PDF format of the request for a discharge notification submission, click the **Preview** button.



Health Care Provider Invoicing and Reporting

Is the customer/ patient being discharged due to *

Met treatment goal

Comment

Met treatment goal.

19 / 750 character limit

* Indicates required field


2

Preview

< Previous

Submit

3. To make a change to the discharge notification submission, click the **Previous** button to return to the section of the submission you wish to modify.
4. Click the **Submit** button to submit the discharge notification submission.
 - a. To submit on the *Preview* section, click the **Submit** button.
 - b. To submit on the *Treatment Extension Request / Discharge Notification* section, click the **Previous** button to exit from the *Preview* section, and click the **Submit** button on the *Treatment Extension Request / Discharge Notification* section.




Health Care Provider Invoicing and Reporting

Customer: Jane Austen Claim number: BB15030-6 Date of accident: 22-NOV-2017 Submit 3 Date: 22-FEB-2019 4a

[Print](#) [< Previous](#) [Submit](#)

Below is the preview of your submission. Please review and click "Previous" if you would like to make any changes.



Health Care Provider Invoicing and Reporting

Customer: Jane Austern Claim number: BB15030-6 Date of accident: 22-NOV-2017 Submission date: 26-FEB-2019

Treatment Extension Request / Discharge Notification

Practitioner/ therapist type *
Occupational Therapy

Practitioner number
Practitioner first name *
Practitioner last name *

Are you requesting treatment extension or notifying of discharge from care? *
☐ Treatment extension ☒ Discharge notification

Discharge date *
30-MAR-2019


Is the customer/ patient being discharged due to *
Met treatment goal

Comment
Customer got well
17 / 750 character limit

* Indicates required field

4b [Preview](#) [< Previous](#) [Submit](#)

5. Save the unique reference number generated for the submission. This number is printed on the PDF version of the submission and on the vendor statement.
6. If an email address was entered on the *Service Provider / Payee Information screen*, click the **Request PDF Copy** button.



Health Care Provider Invoicing and Reporting

Thank you for your submission.


Your reference number for this submission is 19-00001362.

Please record this number as it will be required for future communications regarding your submission.

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[Request PDF Copy](#) [Make another submission](#)

7. A confirmation screen stating that the PDF copy of the submission will be sent within 24 hours will appear.



Health Care Provider Invoicing and Reporting

Thank you for your submission.


An email containing the PDF copy of your submission will be sent within 24 hours.

Your reference number for this submission is 19-00001362.

Please record this number as it will be required for future communications regarding your submission.

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8. If an email address was not entered on the *Service Provider / Payee Information* screen, enter a valid email address in the *Email address* field.
9. Click the **Request PDF Copy** button.




Health Care Provider Invoicing and Reporting

Thank you for your submission.

Your reference number for this submission is 19-00001361.
Please record this number as it will be required for future communications regarding your submission.

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8

Email address 
abc@email.com

9

Request PDF Copy

Make another submission