

**CONTINUATION TO CARRIER/EMPLOYER BILLING PORTION
OF FORMS C-4, C-5, PS-4 or OT/PT-4**

Doctor's Name

WCB Case Number

Carrier Case Number

Date of Accident or Injury

Patient

Patient's Social Security Number:

	A					B	C	D (USE WCB CODE)		E	F		G	H	I
	From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS	Modifier	Diagnosis Code	\$ Charges	Days or Units	COB	Zip Code Where Service was Rendered
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