WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
Toll free 1-855-954-4321 -
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Provider Registration / Change Form

Section I: New Provider Account Request

If you invoice the WCB you must complete Section I and III of this form in order to receive payment. If you work out of more than one clinic or location, you must complete a separate form for each location.

A) Service Provider Information

Provider Type (e.g. physician, medical clinic, educational institute, etc.)				
Last Name	First Name	Legal Name of Company		
Clinic/Business/Operating Name		Clinic/Business Address		
City	Province	Postal Code	Telephone	Fax
Email		Contact Name (if different from above)		
MB Health Billing Number (if applicable)	Specialty Type(s) (if applicable)	Licensing Body Registration ID Number (if applicable)		

B) If client-related correspondence should be sent to an address different than the address in Section A), complete the following:

Business/Clinic/Operating Name (if applicable)	Address	City	
Province	Postal Code	Telephone	Fax
Email		Contact Name	

C) If payment and remittance statements should be sent to an address different than the address in Section A), complete the following (e.g. if billing and payments are managed by a billing company):

Business/Clinic/Operating Name (if applicable)	Address	City	
Province	Postal Code	Telephone	Fax
Email		Contact Name	

To register for direct deposit, please complete the Direct Deposit Form here.

Section II: Provider Account Change

If you are an existing provider and would like to make a change to your existing account, complete Section II and Section III of this form

WCB Account Number	Account Name (as per your last WCB remittance statement)	Effective Date of Change (dd/mm/yyyy)		
Last Name	First Name	Legal Name of Company		
Clinic/Business/Operating Name		Clinic/Business Address		
City	Province	Postal Code	Telephone	Fax
Email		Contact Name (if different from above)		

Section III: Authorization

Please note this form must be completed by the Healthcare Provider or Vendor that will receive payment for claim-related goods and services OR by an Authorized Signing Authority

Date Completed:	Form Completed By:

I certify that the information provided on this form is true, accurate, complete, not false or fraudulent, and is being submitted for the purpose of either creating a WCB provider account for payment of claim-related goods and services, or requesting a change to an existing WCB provider account.

Email this form to: wcbprovideraccounts@wcb.mb.ca,
or fax this form - Winnipeg: 204-954-4999 | toll free: 1-877-872-3804