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