“Cost Bill” Form

(ORS 656.386(2); OAR 438-015-0019)

To:

 (Insurer, Self-Insured Employer, Claim Administrator)

Claimant:

WCB Case No:

Claim No:

Date of Injury:

Hearing Date:

ALJ/Board/Court Order Date:

**EXPENSES AND COSTS** (Itemized)

|  |  |  |  |
| --- | --- | --- | --- |
| **Payee** | **Date of Service** | **Description** | **Amount** |
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|  |  | **Total** | **$** |

 I hereby confirm that the above expenses and costs were incurred in the litigation of the denied claim(s) involving the above-referenced claimant.

 (Claimant or Claimant’s Attorney) (Date)

 (Address)

(Phone)