$684.40

Revised: April 27 2021

**Note: Completed form must be submitted by e-mail to MHRB within 30 days of the hearing Send Email to:** [**Johanna.Barbosa@gov.bc.ca**](mailto:Johanna.Barbosa@gov.bc.ca) **or fax to 604-660-2403.**

Mental Health Review Board

1270 – 605 Robson St.

Vancouver, BC

V6B 5J3

**Print Name:**

If incorporated provide Business address. If not incorporated, please provide home address

**Note: Initials only for the first and last name of the patient. PLEASE DO NOT WRITE THE PATIENT’S FULL NAME**

**PATIENT’s DETAILS**

**SUPPLIER NUMBER:**

**EA:**

**QR:**

**SIGNATURE:**

**105 15FMA 10565 1500000**

**STOB 5507: $ TOTAL: $**

**CASE PRESENTER – BILLING FORM**

**MENTAL HEALTH REVIEW BOARD**

**INVOICE #**

**REVIEW PANEL DETAILS**

**EXPENSE DETAILS –** Boxes below must be completed

**NOTE: incomplete billing forms will be returned to you**

Preparation time which is not otherwise payable as patient care is limited to a maximum of 120 minutes. Only one case presenter per hearing may tender a bill to the MHRB. Completed billing form must be received at the Board Office within 60 days of the hearing. Please confirm with the panel Chair before leaving the hearing, the length of your hearing time.

**Office Use Only**

**Business/GST No.**

**e-mail address:**

**Date:**

MMM/DD/YYYY

**Telephone**

**( )**

**Cheque/Payment to:**

**Name:**

(as it should appear on cheque; co. must be in good standing)

**Current Address:**

Telephone:(604) 660-2325

website: www.bcmhrb.ca

Mental Health Review Board

#302 – 960 Quayside Drive

New Westminster, BC V3M 6G2

**Preparation Time**

**Panel Time**

**Total Minutes**

**Sessional Rate**

**Total**

Review Panel Time

min

min

min

$

**1st PANEL**

**2nd PANEL**

**Patient’s Name**

INITIALS ONLY FOR FIRST AND LAST NAME

INITIALS ONLY FOR FIRST AND LAST NAME

**Facility**

**Panel Date/Time**