

“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
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)