

“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)