"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)