

# STATEMENT FOR HOME NURSING SERVICES



Department of Labor and Industries  
 Crime Victims Compensation Program  
 PO Box 44520  
 Olympia WA 98504-4520

**DO NOT WRITE IN SPACE** >

Claimant's name in full Last	First	Middle	Claim Number
Address			Social Security Number (for ID only)
City	State	ZIP	Reimburse Claimant <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Injury	Name of referring physician or other source		Referring physician provider number / NPI

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable 1. 2. 3. 4. 5.	For glasses, advise if old Rx was available <input type="checkbox"/> Yes <input type="checkbox"/> No Give hospitalization date for inpatient services Admitted _____ Discharged _____	REFUND CERTIFICATION I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof. CLAIMANT'S SIGNATURE:
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FROM DATE OF SERVICE	* POS	PROC CODE	MOD CODE	Describe procedures, medical services or supplies furnished. Attach lab reports, X-ray findings and any special services	Dental Tooth Number	Home Nursing		GLASSES		CHARGES		Unit	TO DATE OF SERVICE
						No. of hrs/day	Hourly/Day rate	OLD RX OD	NEW RX OS	OD	OS		
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													
13.													

Submission of this bill certifies the material furnished, service provided, expense incurred or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid. Signature: _____ Bill date: _____  Remarks: _____	Provider or Supplier name	Provider Number	NPI	Taxonomy
	Address			Total Charge
	City	State	ZIP+4	Phone Number
	Federal tax ID number	<input type="checkbox"/> EIN <input type="checkbox"/> SSN		Your Patient's Account Number

\* Place of Service (POS) codes on back

# INSTRUCTIONS FOR COMPLETING HOME NURSING SERVICES STATEMENT

1. **CLAIMANT'S NAME:** Claimant's full name, last name first.
2. **CLAIM NUMBER:** For the claimant receiving services.  
Crime Victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS".  
Send bills for Crime Victims claims to:  
Department of Labor and Industries  
PO Box 44520  
Olympia WA 98504-4520  
Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department office or the main office in Olympia.
3. **ADDRESS:** The claimant's most current address.
4. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the claimant's name is common.
5. **REIMBURSE CLAIMANT:** Place an "X" in the applicable box. If payment should be made to the claimant, indicate the amount paid.
6. **DATE OF INJURY:** This is important and must be included. One person may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
7. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services.
8. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Crime Victims Compensation Program provider account number or NPI of the referring physician. The number may be obtained from the referring physician.
9. **DIAGNOSIS:** Not applicable.
10. **FOR GLASSES:** Not applicable.
11. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
12. **REFUND CERTIFICATION - FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
  - A. **DATE(S) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (i.e., home nursing care, attendant care) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
  - B. **PLACE OF SERVICE:** A complete list of Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
  - C. **PROCEDURE CODE:** Identifies the procedures used. Enter the appropriate code and describe the procedure. **Enter only one code per line.**
  - D. **CODE MODIFIER:** Not applicable.
  - E. **DENTAL:** Not applicable.
  - F. **HOME NURSING:**  
**Number of Hours or Days:** Enter number of hours per day or number of days per month.  
**Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home nursing services provided.
  - G. **GLASSES:** Not applicable.
  - H. **CHARGES:** Total line item charge.
    - I. **UNIT:** The total hours if an hourly rate was entered in the home nursing column (item "F") or total of days if a daily rate was entered in the home nursing column (item "F").
14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
15. **PROVIDER NUMBER:** Enter Crime Victims Compensation provider account number.
16. **NPI:** Enter the national provider identifier.
17. **TAXONOMY:** Enter the ten -digit taxonomy code.
18. **TOTAL CHARGE:** Total of **all** charges for services provided.
19. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
20. **BILL DATE:** The date your billing was prepared.
21. **TAX IDENTIFICATION NUMBER:** The provider taxpayer identification number for IRS (Internal Revenue Service) reports.
22. **REMARKS:** Any further information necessary to explain your charge.

## ATTACHMENTS

Must have the corresponding claim number listed in the upper right corner of the attachment.

**DUE TO THE FACT THAT THE CRIME VICTIMS' BILL RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.**

The following attachment **is not** acceptable: Office Visit Slips.

## REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "**Rebill**" on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

## PLACE OF SERVICE (POS)

- |   |                              |  |  |
|---|------------------------------|--|--|
| 03. School  | 12. Patient's Home           | 32. Nursing Facility                             | 57. Non-residential Substance Abuse Trmt Facility    |
| 04. Homeless Shelter                              | 13. Assisted Living Facility | 33. Custodial Care Facility                      | 60. Mass Immunization Center                         |
| 05. Indian Health Service Free-standing Facility  | 14. Group Home               | 34. Hospice                                      | 61. Comprehensive Inpatient Rehabilitation Facility  |
| 06. Indian Health Service Provider-based Facility | 15. Mobile Unit              | 41. Ambulance - Land                             | 62. Comprehensive Outpatient Rehabilitation Facility |
| 07. Tribal 638 Provider-based Facility            | 20. Urgent Care Facility     | 42. Ambulance - Air or Water                     | 65. End Stage Renal Disease Trmt Facility            |
| 08. Tribal 638 Provider-based Facility            | 21. Inpatient Hospital       | 49. Independent Clinic                           | 71. State or Local Public Health Clinic              |
| 09. Correctional Facility                         | 22. Outpatient Hospital      | 50. Federally Qualified Hlth Ctr                 | 72. Rural Hlth Clinic                                |
| 11. Office  | 23. Emergency Rm - Hospital  | 51. Inpatient Psychiatric Facility               | 81. Independent Laboratory                           |
|   | 24. Ambulatory Surgical Ctr  | 52. Psychiatric Facility Partial Hospitalization | 99. Other Unlisted Facility                          |
|   | 25. Birthing Ctr             | 53. Community Mental Health Ctr                  |  |
|   | 26. Military Trmt Facility   | 54. Intermediate Care Facility/Mentally Retarded |  |
|   | 31. Skilled Nursing Facility | 55. Residential Substance Abuse Trmt Facility    |  |
|   |                              | 56. Psychiatric Residential Trmt Ctr             |  |