Washington State Department of Labor & Industries

Statement for Option 2 Training

Mail completed forms to:
PO Box 44269
Olympia WA 98504-4269

To bill for Option 2 vocational counseling or job placement, use the Statement for Miscellaneous Services (F245-072-000) form.

Worker Information — Required (Please Print)

Name (Last, First, Middle Initial)			Claim No.
			Date of Injury
Home Address		Apt #	Social Security No. (For ID Only)
City	State	Zip Code	Phone Number

Provider Information (Please Print)

	L&I Provider Number	
Name (Last, First, Middle Initial)	Federal Tax ID	
Address	Phone Number	
City	State	Zip Code

Billing Information (See Back for Instructions)

	From Date of Service	To Date of Service	POS	TOS	Procedure Code	Description of Services or Supplies	Charges	Units
1			99	V				
2			99	V				
3			99	V				
4			99	V				
5			99	V				
6			99	V				
7			99	V				
8			99	V				
9			99	V				
10			99	V				

Total Charge
$

Signature (Only one signature is required. Sign under the appropriate section)

Is this a bill to reimburse the worker?

☐ Yes — Include copies of receipts and sign below.

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Worker's Signature Date

Is this a bill for provider payment?

☐ Yes — Sign below.

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Provider's Signature Date

Instructions for Completing the Statement for Option 2 Training

To bill for Option 2 vocational counseling or job placement, use the Statement for Miscellaneous Services (F245-072-000) form.

Worker Information

Claim Number	Enter the worker's L&I claim number.
Name	Write the worker's legal name in the last name, first name, middle initial format.
Date of Injury	Enter the date of injury.
Home Address	Write the most current physical address of the worker.
Social Security Number	Enter the worker's Social Security Number. Used to verify the claim number.
Phone Number	Enter the phone number where the agency can call if there are any question about this bill.

Provider Information

L&I Provider Number	Enter the provider's L&I provider number.
Provider Name	Write the provider's name as registered with the department.
Provider Address	Write the provider's address.
Federal Tax ID	Enter the Federal Tax ID (EIN) for the billing provider. This must match the EIN on file with the agency.
Phone Number	Enter the phone number where the agency can call if there are any question about this bill.

Bill Information

Use one line for each service provided. Complete each applicable field.

From Date of Service	Enter the starting date of service.
To Date of Service	Enter the ending date of service.
Procedure Code	Enter the appropriate code from the list below. One code per line.
Description	Write a brief description of the services provided.
Units	Enter the total number of units you are billing for.
Charges	Enter the charge for each service provided.
Total Charges	Enter the total for all of the charges on the bill.

Training Codes

R0310	Tuition, Training Fees
R0312	Supplies, Equipment, Tools, Books
R0320	Exams, License Fee
R0350	Other
R0390	Child Care Services

Signature

Only one signature is required.

Worker Signature	If the bill is to reimburse the worker, the worker must sign and date the form. Attach copies of the receipts. All receipts must be itemized and legible.
Provider Signature	If the bill is to reimburse the provider, the provider must sign and date the form.