# STATEMENT FOR CRIME VICTIM MISC SVCS

**Dept of Labor & Industries**
**CVC Program**
**PO Box 44520**
**Olympia WA 98504-4520**

☐ Dental Services
☐ Medical Equipment/ Prosthetics-Orthotics
☐ Transportation
☐ Home Health/ Nursing Home Services
☐ Glasses
☐ Vocational/ Retraining
☐ Other

**DO NOT WRITE IN SPACE** >

| CLAIMANT'S NAME IN FULL First / Middle / Last | Social Security Number (for ID only) | Claim Number |
|---|---|---|
| Address | Date of Birth | Date of Injury |
| City / State / ZIP | Reimburse Claimant ☐ Yes ☐ No | Amount Paid $ |
| Name of referring physician or other source | | Referring physician provider number |

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM, DSM III or DSM IV). Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was available? ☐ Yes ☐ No

Give hospitalization dates 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:

| FROM DATE OF SERVICE | POS | * TOS | 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: No of hrs/day | Home Nursing: Hourly/ Day rate | GLASSES OLD RX OD | GLASSES OLD RX OS | GLASSES NEW RX OD | GLASSES NEW RX OS | CHARGES $ ¢ | Unit | TO DATE OF SERVICE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | | |
| 7. | | | | | | | | | | | | | | | |

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 and that the claim is just and due.

Signature: Bill date: / /

| Provider or Supplier name | Provider number | Total Charge |
|---|---|---|
| Address | | Phone Number |
| City / State / ZIP + 4 | | Your Patient's Account Number |
| Federal tax ID number ☐ EIN ☐ SSN | | |

| Amount paid by Primary Insurance | Name of Primary Insurance Company | PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED. |
|---|---|---|
| $ | | |



* Place of Service (POS) and Type of Service (TOS) codes on back

# INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIM NUMBER:** For the claimant receiving services. Billings cannot be processed without the claim number. Crime victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH or VJ".

   Send bills for Crime Victims claims to:
   Department of Labor and Industries
   PO Box 44520
   Olympia WA 98504-4520

3. **CLAIMANT'S NAME:** Claimant's full name, last name first.
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. **ADDRESS:** The claimant's most current address.
6. **DATE OF BIRTH:** Enter the claimant's date of birth.
7. **DATE OF INJURY:** This is important and must be included. One claimant 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.
8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Crime Victims Compensation Program provider account number of the referring physician. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
10. **DIAGNOSIS:** Indicate both the ICD9-CM, DSM III or DSM IV number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
11. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
    A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
    C. **TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
    D. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
    E. **CODE MODIFIER:** A modified provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
    F. **DENTAL:** To be used for dental services only.
       **Tooth Number:** Identify dental services provided by placing the specific tooth number in the appropriate box.
    G. **HOME NURSING:** To be used for home care only.
       **Number of Hours or Days:** Identify the number of hours or the number of days that the home care services were provided.
       **Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home care services provided.
    H. **GLASSES:** To be used for glasses repair or replacement only.
       Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.
       New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
    I. **CHARGES:** Charges for services provided.
    J. **UNIT:** The sum total of services provided for days, units, or miles, etc.
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 CVC Provider Accounts immediately. (Indicating a new address on the bill **will not** change the CVC's record of address for the provider.)
15. **PROVIDER NUMBER:** Identification number designated by the Crime Victims Compensation Program for the provider.
16. **TOTAL CHARGE:** Total of **all** charges for services provided.
17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
18. **FEDERAL TAX IDENTIFICATION NUMBER:** Enter provider's IRS (Internal Revenue Service) federal tax identification number. Indicate by marking box whether federal tax ID number is EIN or SSN.
19. **AMOUNT PAID BY PRIMARY INSURANCE:** As Crime Victims Compensation is a secondary insurer, private or public insurance must be billed first. Enter amount paid by private or public insurance. Attach a copy of the explanation of benefits for payments and denials.
20. **NAME OF PRIMARY INSURANCE COMPANY:** Enter name of private or public insurance company making payments on behalf of the claimant.

**ATTACHMENTS**

The following attachments **must be** submitted with billings for appropriate services:

1. X-ray findings
2. Lab reports
3. Office notes
4. Operative reports
5. Emergency Room reports
6. Diagnostic Study reports
7. Cost invoice of supplies furnished
8. Consultation reports

Each attachment 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 one hundred twenty (120) 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.

**TYPE OF SERVICE (TOS)**

| | |
|---|---|
| C Chiropractic Services | P Physical Therapy |
| D Drugless Therapeutics | V Vocational Services |
| I Inpatient | 3 Medical Services |
| M Mental Health Counselors | 4 Dental |
| N Nurse Practitioner Services | 9 Ancillary Services (attendant, equipment, glasses) |
| O Outpatient | |

**PLACE OF SERVICE (POS)**

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